No. 80-2085

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IN THE

SUPREME COURT OF THE UNITED STATES

October Term, 1980

GERIATRICS, INCORPORATED
doing business as
EVENTIDE OF LAKEWOOD NURSING HOME,

Petitioner,

vs.

PATRICIA HARRIS, Secretary of the United States Department of Health, Education and Welfare, DARREL MUHR, Regional Health Standards and Quality Directory, United States Department of Health, Education and Welfare,

COLORADO DEPARTMENT OF HEALTH
and
FRANK TRAYLOR, M.D.,
Executive Director of the Colorado Department of Health;

COLORADO DEPARTMENT OF SOCIAL SERVICES
and
ARMANDO ATENCIO, Executive Director of the Colorado Department of Social Services;

JEFFERSON COUNTY DEPARTMENT OF SOCIAL SERVICES
and
NELSON L. NADEAU, Director of the Jefferson County Department of Social Services;
and
STUART G. BARR, a Hearings Officer of the State of Colorado,

Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE TENTH CIRCUIT

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June 8, 1981.

QUESTIONS PRESENTED FOR REVIEW

1. Is a nursing care facility's continuing certification and accompanying reimbursement as a Medicare and Medicaid provider of services to eligible recipients a property interest requiring procedural protections mandated by the Fifth and Fourteenth Amendments to the United States Constitution?

2. If so, should the facility be afforded an opportunity for an evidentiary administrative hearing prior to the termination of certification and reimbursement by federal and state governments?

3. Is a provider's Medicare and Medicaid certification and reimbursement sufficiently integrated with the facility's continued operation so as to be equivalent to its operating license?

4. Did Congress intend that a provider under the Medicare and Medicaid programs be afforded a pretermination hearing?

PARTIES BELOW

1. Geriatrics, Inc. d/b/a Eventide of Lakewood Nursing — plaintiff/appellant. [Geriatrics, Inc. is a wholly owned subsidiary of ARA Health Care Group, Inc. which is a wholly owned subsidiary of ARA Services, Inc.]

2. Ruby Arnold, and other residents of Eventide of Lakewood — plaintiffs/intervenors/appellees. [This matter arose prior to this Court's opinion in *O'Bannon v. Town Court Nursing Center*, 447 U.S. 773 (1980). As a result of that decision the residents who intervened below are not included as parties here.]

3. Patricia Harris, Secretary of the United States Department of Health, Education and Welfare, and Darrel Muhr, Regional Health Standards and Quality Director, United States Department of Health, Education and Welfare — defendants/appellants (federal respondents).

4. Colorado Department of Health; Frank Traylor, M.D., Executive Director of the Colorado Department of Health; Colorado Department of Social Services; Armando Atencio, Executive Director of the Colorado Department of Social Services; and Stuart G. Barr, a Hearings Officer of the State of Colorado — defendants/cross-claimants/appellees (state respondents).

5. Jefferson County Department of Social Services and Nelson L. Nadeau, Director of the Jefferson County Department of Social Services — defendants.

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OPINION BELOW

The opinion and judgment of the United States Court of Appeals for the Tenth Circuit which appears in the Appendix at page 16, *infra.*, is reported at 640 F.2d 262 (10th Cir. 1981). The findings of fact, conclusions of law and entry of a preliminary injunction by the United States District Court for the District of Colorado on October 22, 1979 is not reported. It is reprinted in the Appendix at page 24, *infra.*

JURISDICTION

The opinion and judgment of the United States Court of Appeals for the Tenth Circuit was entered on January 26, 1981. A petition for rehearing and suggestion for rehearing in banc was denied on March 9, 1981 and this petition for a writ of certiorari is filed within ninety (90) days of that date. The order denying the petition for rehearing is reprinted in the Appendix at page 43, *infra.* This Court's jurisdiction is invoked pursuant to 28 U.S.C. § 1254(1) (1976).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

42 U.S.C. § 1395, *et seq.* (1976 & Supp. III, 1979)
42 U.S.C. § 1396, *et seq.* (1976 & Supp. III, 1979)
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- § 24-4-104(11)
- § 25-1-107(1)(l)(I)
- § 25-1-120
- § 25-3-101, *et seq.*
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The pertinent provisions are reprinted in the Appendix at page 45, *infra*.

STATEMENT OF THE CASE

1. NATURE OF THE CASE.

Petitioner originally filed this action in the District Court seeking injunctive relief, a declaratory judgment and judicial review to contest the decision and forthwith procedures utilized by respondents in refusing to renew the license, Medicare and Medicaid certification and accompanying reimbursement agreements of its nursing care facility, Eventide of Lakewood (Eventide). In order to obtain a "pretermination hearing," petitioner requested a temporary restraining order and a preliminary and permanent injunction enjoining the agencies from terminating Eventide as a Medicare and Medicaid provider of services. This relief was requested since the respondents' actions would result in the involuntary relocation of facility residents to other nursing homes, thereby forcing Eventide to close.

2. COURSE OF PROCEEDINGS.

The complaint for injunctive relief and the motions for a temporary restraining order and preliminary injuction were filed on September 17, 1979. A preliminary conference by the court with counsel for the parties was held that same day concerning the residents and their representation at any hearing in the case. The court subsequently appointed counsel for the residents and petitioner agreed to pay one-half of the fees and costs, the other one-half being contributed *pro bono*, when the respondents declined to participate as to the residents' representation.

On September 26, 1979, following an evidentiary hearing, the court entered a temporary restraining order enjoining respondents from either terminating or otherwise causing the Medicare or Medicaid reimbursement to petitioner or its eligible residents to cease; prohibiting respondents from causing the involuntary transfer, relocation or removal of residents from Eventide; or in any other manner impairing petitioner's or its residents' participation in the Medicare or Medicaid programs pending a hearing on the request for a preliminary injuction.

Following the intervention of the residents, individually and as a class, a hearing was conducted on the request for a preliminary injunction and evidence presented by petitioner in support of the temporary restraining order was admitted through stipulation. The court heard additional testimony and subsequently made an extensive oral ruling granting a preliminary injuction. (Appendix at page 24, *infra*.).

3. DISPOSITION IN THE COURTS BELOW.

The District Court issued its order enjoining respondents from withholding reimbursement to Eventide until a hearing was afforded on the basis that the facility and its residents, including Medicaid recipients, were entitled to a pretermination hearing as a matter of due process of law. Until that hearing, petitioner's license, certification and reimbursement agreements under Medicare and Medicaid were to remain intact. The Court further restrained the federal government from terminating its financial participation for Medicaid as to petitioner's reimbursement until conclusion of the hearing.

The United States Courts of Appeals for the Tenth Circuit reversed, concluding that petitioner had no expectation of continued Medicare or Medicaid program participation and, therefore, no protectable property interest. During the appeal the question as to the patients' interests in a facility's program participation was decided in *O'Bannon v. Town Court Nursing Center*, 447 U.S. 773 (1980), and the Tenth Circuit held accordingly.

4. STATEMENT OF THE FACTS.

A. The Statutory Scheme.

This matter involves two public assistance programs. The first is the Federal Health Insurance for the Aged and Disabled, or "Medicare", Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395, *et seq.* (1976 & Supp. III, 1979). Part A of Medicare provides hospital insurance benefits, including skilled nursing care in facilities like Eventide, for eligible beneficiaries. It is federally funded and administered by the Secretary of Health, Education and Welfare (now Health and Human Services).

The other is the Colorado Medical Assistance Program which is this state's "Medicaid" program. Medicaid is a matching grant program and when this case arose, the federal government contributed approximately 54% of its cost in Colorado. To be eligible for federal participation, a state Medicaid program must comply with the requirements of Title XIX of the Social Security Act, 42 U.S.C. § 1396, *et seq.* (1976 & Supp. III, 1979). Colorado's participation in the program is established under Article 4 of Title 26 and § 26-1-109(1), Colo. Rev. Stat. 1973, as amended (1980 Supp.) which is administered by the Department of Social Services (Social Services). This program assists individuals whose income and other resources fall below prescribed levels by reimbursing providers for a variety of health care related benefits including inpatient nursing services in qualified facilities.

An individual eligible for Medicare or Medicaid may obtain benefits from any institution, agency, pharmacy, or person, qualified to perform the service or services required. 42 U.S.C. §§ 1395a (1976), 1396a(a)(23) (Supp. III, 1979). In order to qualify for Medicare and Medicaid reimbursment, a facility must meet the definition of a skilled nursing facility under 42 U.S.C. § 1395x(j) (1976 & Supp. III, 1979). Unlike Medicare, Medicaid permits participation by "intermediate care facilities," which provide care to individuals who do not require the full range or intensity of services furnished by

hospitals or skilled nursing facilities. 42 U.S.C. § 1396d(a)(15) & (c) (1976 & Supp. III, 1979). The requirements for an intermediate care facility's participation in the Medicaid program are contained in 42 C.F.R. Part 442, Subparts E and F (1980). A facility like Eventide may be qualified to provide both types of services.

To qualify as a provider of services under either program requires the "certification" by a "state survey agency" through an inspection process called a "survey." In the case of Medicare, the Secretary has an agreement with the state survey agency (in Colorado, the Department of Health) to perform surveys to determine if the facility meets a series of compliance regulations referred to as "conditions of participation," which set forth operational standards for the skilled services provided recipients. 42 U.S.C. § 1395aa(a) (Supp. III, 1979); 42 C.F.R. § 405.1101, *et seq.* (1980). For Medicaid, Social Services has an agreement with Health to conduct surveys under the same conditions for skilled services and applicable regulations for intermediate care facilities. 42 U.S.C. § 1396a(a)(9) & (28) (1976); 42 C.F.R. Part 442, Subparts E and F (1980). Health, as a related function in Colorado, must also annually inspect nursing homes to determine if they meet state licensing regulations. §§ 25-1-107(1)(l)(I), and 25-3-101, *et seq.*, Colo. Rev. Stat., 1973, as amended (1980 Supp.).

Each condition of participation for a skilled facility represents a major division of institutional service or environmental protection to be furnished by a facility. The conditions are further divided into "standards" which are often subdivided into specific components called "factors" or "elements." Surveys are utilized to evaluate a facility's compliance and must be conducted at least once each year. 42 C.F.R. §§ 405.1903, 442.15 (1980); § 25-1-107(1)(l)(I), Colo. Rev. Stat., 1973, as amended (1980 Supp.). Therefore, as a practical matter, surveys for program compliance and state licensing standards are usually scheduled simultaneously and performed by the same inspectors.

In the survey process, the inspectors prepare findings as to a facility's non-compliance and its failure to meet any of the regulations is called a "deficiency." A facility responds to the deficiences by submitting to the survey agency a "plan of correction" stating what it will do to meet the regulations and when compliance will be accomplished. This plan is reviewed by the survey agency for a determination of its acceptability under the regulations.

A facility may continue to be certified and, therefore, participate in both programs even though it has deficiencies where it has submitted an acceptable plan of correction and the deficiencies, individually or in combination, do not jeopardize the health or safety of its residents or limit the facility's capacity to render adequate care. 42 C.F.R. §§ 405.1907, 442.105 (1980). However, as to a skilled facility, if a condition of participation, as opposed to a standard or element, is judged not to be in compliance the facility cannot be certified as that finding is a determination that the institution does not meet the definition of a skilled nursing facility. 42 U.S.C. §§ 1395x(j), 1395cc(b) (1976 & Supp. III, 1979). In the case of a facility certified for both programs, a decision to terminate certification by the Secretary under Medicare is binding as to Medicaid and any appeal by the provider is governed by federal regulations. 42 C.F.R. §§ 431.153(d), 442.20 (1980).

A facility's reimbursement is memorialized in an enrollment document called a provider agreement and decertification, by regulation, causes a termination within thirty days of notice. 42 C.F.R. § 489.16(b) (1980). For Medicare, this agreement is with the Secretary, while under Medicaid, it is with the "single state agency" responsible for the administration of the state Medicaid program (in Colorado, Social Services). In the case of a facility which participates in both programs, federal regulations require that both agreements be of the same duration and like certification, the renewal or termination of the agreements is effectively controlled by the Secretary and a provider may only contest these determinations under the appeal procedures provided in 42 C.F.R. Part 405, Subpart O. 42 C.F.R. § 431.153(d)

(1980). These regulations make no provision for a pretermination hearing.

B. The Facts of This Case.

When the proceedings below were initiated, Eventide was qualified to deliver skilled and intermediate nursing services, having a licensed capacity of 180 beds and a patient census of 137. Its license, Medicare and Medicaid certification and provider agreements were due to expire on August 31, 1979. Eventide applied for a renewal of each in a timely manner; however, before expiration, the petitioner received the following notices:

1. Health notified that renewal of Eventide's license and Medicaid certification would be denied on the basis of alleged deficiencies found during the course of a survey.

2. The Secretary advised that in accordance with Health's recommendations, the renewal of Eventide's Medicare certification and provider agreement would be denied and reimbursement for Medicare patients would cease thirty (30) days after August 31, 1979.

3. Social Services notified that, in accordance with the recommendations of Health and the actions of the Secretary, renewal of the Medicaid agreement must be refused, and reimbursement for Medicaid residents would cease thirty (30) days after August 31, 1979.

Eventide appealed and requested each agency to postpone or stay these actions pending a full hearing.

As to the state respondents, a state hearing officer issued a stay as to the termination of the facility's license and Medicaid certification, but denied the request as to the refusal to renew the Medicaid provider agreement. Since approximately 85% of its residents were Medicaid eligible, and would have to be relocated within thirty days, a stay or postponement of agency action was a prerequisite to Even-

tide's continued operation. Therefore, when petitioner's request for a stay was denied, the action was instituted in the District Court. No similar request was made as to federal respondents since at that time the facility had no currently eligible Medicare patients.

At the hearing for a temporary restraining order, Eventide presented evidence that 116 of its 137 residents received some form of assistance through Medicaid which generated revenue of approximately $95,000.00 each month. Since total monthly revenue averaged $128,000.00, Eventide could not continue in operation upon losing its Medicaid funding and would be required to relocate all residents of the facility. Eventide further asserted that involuntary relocation of elderly residents could have a severe mental and physical effect on patients (called "transfer trauma") which was supported by the testimony of two physicians, one of whom was the facility's Medical Director. A number of the patients testified that they were receiving adequate care and indicated a unanimous desire to participate in a hearing before relocation. Following this evidence, the court entered its oral ruling granting the preliminary injunction.

REASONS FOR GRANTING THE WRIT

1. The decision below conflicts with the decisions of other Courts of Appeals.

The Tenth Circuit's determination that Eventide does not have a protectable interest is contrary to decisions in other circuits. One of the first circuit cases concerning a nursing facility's right to continued participation in the programs was *Maxwell v. Wyman*, 458 F.2d 1146 (2d Cir. 1972). There a trial court's refusal to grant a preliminary injunction was reversed thereby preventing the attempted decertification and closure of several facilities as a result of their alleged failure to meet federal regulations as to building code requirements. Implicit in this ruling was the recognition that these facilities have a property interest in continued participation. Although the court did not expressly reach the merits of the facilities' claim that they were, as a

matter of federal constitutional law, entitled to hearing under *Goldberg v. Kelly*, 397 U.S. 254 (1970), it determined that the homes had a reasonable probability of success in their argument that the attempted decertifications were tantamount to a revocation of their operating licenses. n. 7, 458 F.2d at 1151. This is discussed later at p. 13, *infra*.

The next case of import to reach a Court of Appeals was (also in the Second Circuit) *Case v. Weinberger*, 523 F.2d 602 (1975). There it was held generally that the proprietor of a nursing facility has a property interest in continued participation in Medicaid and under ordinary circumstances should be provided with a hearing comporting with the requirements of due process prior to termination. *Id.* at 606. However, the court refused to order the hearing because the record reflected that facility conditions were such that the health and safety of the residents were in jeopardy. Based upon these limited circumstances, the court held that a formal evidentiary hearing could be deferred.

As a logical extension of *Case*, the Seventh Circuit subsequently held that where there is no immediate jeopardy to the health and safety of the patients, a provider's continued expectation to receive program reimbursement is a property interest that requires a pretermination hearing. *Hathaway v. Mathews*, 546 F.2d 227, 230-232 (1976). The Tenth Circuit attempts to distinguish this holding as to Eventide on the basis that in *Hathaway*, the two governmental agencies (federal and state) responsible for determining participation disagreed as to the facility's compliance. This begs the question as it is of no importance, if there is a protectable property interest, which agency attempts to remove the facility from the programs.

The next circuit presented with this issue was the Third in *Town Court Nursing Center, Inc. v. Beal*, 586 F.2d 266 (1978). That court concluded that the facility asserted an interest that was arguably within the "zone of interests" to be afforded due process, but held that a "post-termination" hearing was sufficient to effectively protect that interest.

The Third Circuit's determination that this interest was adequately protected by a post-termination hearing was based upon assumptions that one other court has recently questioned. *Rockhill Care Center, Inc. v. Harris*, 502 F. Supp. 1227 (W.D. Mo. 1980). This is discussed at p. 11, *infra*.

Other decisions include the Fourth Circuit's *per curiam* affirmance which implicitly recognized the existence of a protectable interest where the court below had held that a facility's interests were protected by a due process hearing by the state agency revoking certification. *Caton Ridge Nursing Home, Inc. v. Califano*, 447 F. Supp. 1222 (D. Md. 1978) aff'd. 596 F.2d 608 (4th Cir. 1979). Two other federal courts have also recognized the same interest in a facility's continued participation in the Medicaid program. *Ross v. State of Wisconsin Department of Health and Social Services*, 369 F. Supp. 570, 571-572 (E. D. Wis. 1973) (three-judge court) and *Rockhill Care Center, Inc. v. Harris, supra*.

The only circuit decision that lends support to the conclusion that there is no protectable interest is *Green v. Cashman*, 605 F.2d 945 (6th Cir. 1979). Although clearly *dictum*, that court noted that the relationship between the provider and the government was purely contractual. There are some state cases that support the conclusion that there is not a protectable interest. *Paramount Convalescent Center, Inc. v. Department of Health Care Services*, 15 Cal. 3d 489, 542 P.2d 1, 125 Cal. Rptr. 265 (1975), cert. denied 425 U.S. 992 (1976); *Marshall Nursing Homes, Inc. v. Aggrey*, 50 Ohio App. 2d 15, 361 N.E. 2d 522 (1976); and *State Department of Social Services v. Rodvik*, 264 N.W. 2d 898 (S.D. 1978).

2. There is significant post-*O'Bannon* confusion concerning the rights of providers participating in the Medicare and Medicaid programs.

In *O'Bannon v. Town Court Nursing Center, supra*, this court determined that program recipients residing in a facil-

ity subject to a decertification action by federal and state agencies, do not have an interest that is directly affected by that action so as to require, at their request, a pretermination hearing. Justice Steven's analysis at 447 U.S. at 788 states:

> The simple distinction between government action that directly affects a citizen's legal rights, or imposes a direct restraint on his liberty, and action that is directed against a third party and affects a citizen only indirectly or incidentally, provides a sufficient answer for all of the cases on which the patients rely in this Court...

However, there can be no doubt that the programs and their regulatory framework create a direct relationship between the provider and the government. Since governmental action to remove a nursing home from the programs threatens the provider's continued existence, this cannot be termed incidental to the type of potential harm addressed in *O'Bannon* as to the residents. Here, the government's actions are intended to directly and adversely affect the facility and petitioner asserts that this interest should be afforded constitutional protection in the form of a pretermination hearing.

The government, before the Tenth Circuit, expressed its belief that *O'Bannon* infers approval of the holding in *Town Court Nursing Center, Inc. v. Beal, supra,* where it was determined that such interests were sufficiently protected by "informal" procedures and a post-termination hearing. Reply brief of appellant at 4. Analysis of *Town Court* reveals that its decision was based on the due process criteria of *Mathews v. Eldridge,* 424 U.S. 319 (1976). Petitioner contends that there are material distinctions between the governmental actions complained of in *Town Court* and those pertaining to Eventide and that many of the assumptions relied upon by the Third Circuit in *Town Court* were undisputed by those parties while they are directly challenged here by Eventide.

For instance, in *Town Court* it was assumed by the Third Circuit that the agency's decision to terminate was an "easily documented, sharply focused decision in which issues of credibility and veracity play little role (and that such decisions are based) upon routine, standard, unbiased reports by health care professionals (who) evaluate the provider in light of well-defined criteria that was developed in the administrative rule-making process." 586 F.2d at 277. Eventide has strenuously urged and intended to demonstrate at a hearing that these assumptions are naive and faulty. The agency decisions to terminate Eventide's participation in the program were based upon conclusions that were, at best, cursory and subjective. Petitioner contends that the survey process delegates unfettered discretion to inspectors (who are not all health care professionals) to determine the weight to be placed on deficiencies and their importance in the ultimate decision to decertify the facility. In short, Eventide maintains that the agency reports in this case were not "routine, standard and unbiased."

Since *O'Bannon* was decided at least one lower federal court, after hearing evidence on contentions similar to Eventide's, has questioned the Third Circuit's appiication of *Eldridge* principles to a facility's decertification. In *Rockhill Care Center, Inc. v. Harris, supra* at 1233, Judge Sachs preliminarily found:

> The Court's last observation is contrary to the stated assumptions of *Town Court,* but is based on what this Court has heard in two days of testimony. The decision not to renew this provider agreement was not "an easily documented, sharply focused decision in which issues of credibility and veracity play little role." (Citation omitted). The Court has reason to question that it is faced with "routine, standard, unbiased reports by health care professionals (working from) well-defined criteria. . ." Rockhill contends, and the Court finds some plausibility in the contention, that the survey conclusions were quite subjective in nature,

> that the weight placed on various deficiencies was not easily definable nor cleary reasonable, and that, in at least the closing states of the scenario, impatience and annoyance may have well become factors...

These important contentions can only be effectively heard and fully determined in the course of a pretermination hearing.

Moreover, this Court in *O'Bannon* noted that the holding did not consider "state-law arguments" made by the patients based upon their asserted status as third party beneficiaries to the provider agreement and a right to continued care in the home of their choice by virtue of Pennsylvania's "long history of providing free medical care for those who are indigent." n. 17, 447 U.S. at 785. Eventide advanced separate state-law arguments based upon Colorado statutes and regulations which were not addressed by the Tenth Circuit.

Colorado statutes do not permit Health to limit or place conditions upon a health care facility's license without a prior hearing. § 24-4-104(11) & 25-3-103(4), Colo. Rev. Stat. 1973. Petitioner asserts that it is impossible to separate the licensing, certification and reimbursement functions since a decision concerning one entitlement constitutes a significant limitation on the other. *Maxwell v. Wyman, supra,* at 1151. Further, Colorado has adopted a statute commonly called the "Patients' Bill of Rights," [§ 25-1-120, Colo. Rev. Stat. 1973, as amended, (1980 Supp.)] and the Colorado Court of Appeals has recently upheld a resident's statutory right to a pretransfer administrative hearing for any patient who desires to contest relocation based upon medical reasons. *MacLeod v. Miller,* ____ Colo. App. ____, 612 P. 2d 1158 (1980).

3. The decision below ignores clear congressional intent to require a pretermination hearing.

The Social Security Act states that a provider of services

who is dissatisfied with a determination by the Secretary that it is not qualified is entitled to a hearing and to judicial review. 42 U.S.C. §1395ff(c) (1976). This provision was originally adopted in 1965 and the clear congressional intent is that a pretermination hearing is to occur before a provider is removed from program participation. This intent is further evidenced in a Senate Report which stated "the Secretary would be required to give reasonable notice and an opportunity for hearing to a provider of services before making a final determination that the provider does not qualify to participate." S. Rep. No. 404, 89th Cong., 1st Sess., [U.S. Code Cong. & Admin. News, 89th Cong., 1st Sess. 1943, 1991-1992 (1965)]. A copy of the relevant provision appears in the Appendix at p. 73, *infra*.

This mandate has been reaffirmed in recent amendments to the Social Security Act authorizing the Secretary and single state agencies to impose so-called "intermediate" sanctions other than the outright termination of a provider when conditions so warrant. Pub. L. No. 96-499, § 916. Effective upon President Carter's signature on December 5, 1980, the congressional reports issued concerning this legislation state: "termination could not take effect until the affected facility had been provided an opportunity for a hearing... that it failed to meet the requirements for participation." H. R. Rep. No. 96-1167, 96th Cong., 2d Sess. 55-58 [U.S. Code Cong. & Admin. News, 96th Cong., 2d Sess. 5526, 5568-5571 (1980)]. A copy of the pertinent section of this report appears in the Appendix at p. 75, *infra*. This is not a change in the current law which provides "access to a full evidentiary hearing before decertification of a facility occurs." H. R. Conf. Rep. No. 96-1479, 96th Cong., 2d Sess. 140-141 [U.S. Code Cong. & Admin. News, 96th Cong., 2d Sess. 5903, 5931-5932 (1980)]. A copy of the appropriate section appears in the Appendix at p. 79, *infra*.

CONCLUSION

For these reasons, a writ of certiorari should issue to review judgment and opinion of the United States Court of Appeals for the Tenth Circuit.

Respectfully submitted,

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June 8, 1981. Counsel for Petitioner

APPENDIX A

UNITED STATES COURT OF APPEALS
TENTH CIRCUIT

No. 79-2317

GERIATRICS, INC., d/b/a EVENTIDE OF LAKEWOOD NURSING HOME,	)	
Plaintiff/Appellee,	)	
RUBY ARNOLD, *et al.,*	)	
Plaintiffs-Intervenors/ Appellees,	)	On Appeal From The United States District Court For The District of Colorado (D.C. No. 79-W-1286)
v.	)	
PATRICIA HARRIS, *et al.,*	)	
Defendants/Appellants,	)	
COLORADO STATE DEPARTMENT OF HEALTH, *et al.,*	)	
Defendants-Cross Claimants/ Appellees.	)	

Submitted on the briefs:

Joseph Dolan, United States Attorney, and William C. Danks, Assistant United States Attorney, Denver, Colorado, Ronald S. Luedemann, Regional Attorney, and Richard K. Waterman, Assistant Regional Attorney, Department of Health, Education and Welfare, Denver, Colorado, of counsel, for Defendants-Appellants.

Frederick Miles and Richard G. McManus, Jr., of Miles & McManus, Denver, Colorado, for Plaintiff-Appellee.

Richard N. Stuckey, of Keene, Munsinger & Stuckey, Denver, Colorado, for Plaintiffs-Intervenors/Appellees.

J. D. MacFarlane, Attorney General, State of Colorado, Richard F. Hennessey, Deputy General, Mary J. Mullarkey, Solicitor General, and Maurice G. Knaizer, Assistant Attoreny General, Human Resources Section, Denver, Colorado, for Defendants-Cross Claimants/Appellees.

Before SETH, Chief Judge, LEWIS and SEYMOUR, Circuit Judges.

SETH, Chief Judge.

After examining the briefs and the appellate record, this three-judge panel has determined that oral argument would not be of material assistance in the determination of this appeal. *See* Fed. R. App. P. 34(a); Tenth Cir. R. 10(e). The cause is therefore ordered submitted without oral argument.

This is an appeal from a preliminary injunction which enjoined Secretary Harris of HEW and the Colorado State Department of Health from terminating Medicaid funding of plaintiff Geriatrics' Eventide of Lakewood Nursing Home prior to a hearing to ascertain whether the Home is in compliance with federal and state regulations.

HEW appeals and contends that an evidentiary hearing is not required before it terminates its Medicaid funding of a nursing home which has failed to meet the basic standards.

Eventide of Lakewood Nursing Home has for some time been licensed by the state as a skilled nursing facility and has therefore been eligible to participate in the Medicare and Medicaid programs. The Home has approximately 146 residents, of whom 116 rely on Medicaid payments. These payments are made pursuant to provider agreements between the Home and the State of Colorado, as required under the federal Social Security Act.

Eventide's operating license and its Medicare and Medicaid provider agreements were all due to expire in August 1979. The State Department of Health, as the agency responsible for the inspection of participating facilities for compliance with regulations pertaining to health care standards, conducted a complete survey of Eventide in May 1979. The purpose was to ascertain whether Eventide's license and provider agreements should be renewed. The inspection revealed that Eventide was seriously deficient in many areas of operation and the state concluded that Eventide did not comply with federal and state regulations regarding nursing services and infection control. 42 C.F.R. §§ 405.1124, 405.1135 (1979). The state furnished Eventide with a thirty-seven page deficiency list detailing the particulars. As required, Eventide returned the list with its proposed plan of corrections for review.

By letter dated July 27, the state notified Eventide of its intention not to renew the Home's license and certification required for participation in the Medicaid program. This action was based on recurrent violations of federal and state operating standards as revealed by several surveys conducted over the past few years and by the inspection conducted the previous May. The letter also informed Eventide that the state was recommending that the Home's Medicaid provider agreement and Medicare certificate not be renewed. The letter also set a hearing on the matter for August 27, 1979. HEW followed the state's recommendation, notified Eventide, and informed it of its right to an administrative reconsideration of this action. 42 C.F.R. § 405.1510 (1979) requires the appropriate state agency to take the

same action as HEW regarding its provider agreements so the state informed Eventide that its Medicaid provider agreement would expire by its terms on August 31, 1979 without renewal.

Eventide appealed the state agencies' actions by letters dated August 7 and 21 and requested that the denials be stayed pending a hearing. At the August 27 hearing, a state hearing officer granted the motion as to the license and Medicaid certification, but denied the request as to the Medicaid provider agreement. Eventide requested reconsideration of the HEW non-renewal on September 25, within the sixty days allowed, 42 C.F.R. § 405.1511(b) (1979), but this was almost a month after the expiration of the HEW agreement. Prior to this request Eventide had started this suit seeking injunctive relief, declaratory judgment, and judicial review of the agencies' actions.

The patients at Eventide contended that their interests would be adversely affected by a cessation of benefits to the Home so that they too were entitled to a hearing before funding is terminated. The district court appointed counsel to represent the residents at the Home and permitted them to intervene.

Regulations require that after a nursing home has been decertified the home is not to admit Medicare or Medicaid patients, and the funded residents are to be relocated. Funding stops within thirty days following the expiration of the home's provider agreements. 42 C.F.R. § 441.11(a) (1979). The court heard evidence that relocation of patients would cause trauma; that the cessation of funding would adversely affect the Home's financial condition; and that the Home had by then corrected several deficiencies. The trial court ordered the agencies not to terminate funding until a hearing to establish the status of the Home's compliance with federal regulations was conducted. He also allowed the Home to continue to admit Medicare and Medicaid patients.

An initial issue is whether the residents of Eventide are entitled to a hearing before the government may suspend

the nursing home they occupy from participation in the Medicaid program. The case of *O'Bannon v. Town Court Nursing Center*, ____ U.S. ____, 48 U.S.L.W. 4842 (June 23, 1980), is dispositive of this issue. The Court there held that no such constitutional right exists. The Court noted that the patients receive benefits from the government in the form of payment for certain medical services. These cannot be withdrawn without notice and hearing, but a decision to decertify a nursing home is not an action depriving the residents of their direct benefits. The indirect adverse effect does not create a constitutional right.

Eventide asserts that it had an expectation of continued participation in the Medicaid program and this was a "property interest" to be protected under due process. Also, that it had more than a unilateral claim or mere expectancy. Board of Regents v. Roth, 408 U.S. 564, 577.

A protectable property interest must be an interest secured by statute or legal rule or through a mutually explicit understanding. *Leis v. Flynt*, 439 U.S. 438, 441-42; *Perry v. Si. dermann*, 408 U.S. 593, 601; *Chavez v. City of Sante Fe Housing Authority*, 606 F. 2d 282, 284 (10th Cir.); *Coleman v. Darden*, 595 F. 2d 533 (10th Cir.).

The regulations require the Secretary to inform a nursing facility that its agreement will not be renewed and to state the reasons for nonrenewal, 42 C.F.R. § 405.604(c) (3) (1979) (to be recodified at 42 C.F.R. § 489.16 (b) (1)), and further provide for the opportunity for full administrative review. 42 C.F.R. §§ 405.1501 - 405.1595 (1979). *See also* Colorado Department of Social Services Regulations §§ A-4900.01 and A-4900.01-5. These provisions taken alone may appear to create an expectation between government and facility of renewal. However, when the entire regulatory scheme is considered no basis appears for such an expectation.

Federal law limits provider agreements to one year. 42 U.S.C. § 1395cc(a) (1); 42 C.F.R. § 442.15(a). The state must assure the HEW that the home is licensed, must certify that

it meets the standards as set forth in the federal regulations, 42 C.F.R. §§ 442.101 and 442.201 (1979), and inspect the facility at least once a year to assure compliance with the regulations. 42 C.F.R. § 456.606 (1979). The manifest intent of limiting the term of a provider agreement to one year is to assure that an automatic termination occurs and a new agreement may be entered into if the facility is in compliance. This limitation provides an incentive to a nursing home to consistently render adequate care to its Medicaid patients. The regulations thus impose upon a facility the burden of demonstrating annually that it complies with the appropriate standards.

The mutual understanding extant here was that Eventide's provider agreement was to expire August 31, 1979, and it contained no provision as to renewal. The Home understood that a new one would not issue unless it could affirmatively show it was qualified. Thus the facts are not distinguishable from *Board of Regents v. Roth*, 408 U.S. 564, wherein it was held that an untenured teacher employed under a contract without a specific expiration date had a more unilateral hope of renewal. Eventide thus had at most a unilateral hope that new provider agreements would be executed, but such unilateral hope cannot constitute a protected "property" interest as to require a pre-termination hearing. *Paramount Convalescent Center, Inc. v. Department of Health Care Services*, 15 Cal. 3d 489, 542, P.2d 1, 125 Cal. Rptr. 265, *cert. denied*, 425 U.S. 992; *Marshall Nursing Homes, Inc. v. Aggrey*, 50 Ohio App. 2d 15, 361 N.E. 2d 522; *State Department of Social Services v. Rodvik*, 264 N.W. 2d 898 (S.D.). The administrative review of an adverse decision by HEW is designed to protect a home's interest. The regulations allow the home the opportunity to demonstrate compliance. *Town Court Nursing Center, Inc. v. Beal*, 586 F.2d 266 (3d Cir.). There is, however, no statutory or constitutional requirement that a hearing be conducted prior to the cessation of benefits.

Eventide is not the intended beneficiary of the Medicaid program. Instead, the purpose underlying the funding pro-

gram is to extend financial benefits to the patients eligible to receive their medical care at government expense. 42 U.S.C. § 1395a. Eventide argues also that termination of benefits would force the Home to close and that it therefore has a significant financial interest to retain its certification. The Home's financial need for government assisted patients is incidental to the purpose and design of the program. Eventide's operating license has not been rescinded and it may still operate as a nursing home and render care to private-pay patients. The unfortunate reality that it will probably encounter difficulty operating at capacity is not of constitutional significance. *See Town Court Nursing Center, Inc. v. Beal,* 586 F.2d 266 (3d Cir.); *Case v. Weinberger,* 523 F.2d 602, 607 (2d Cir.).

The Third Circuit panel in *Town Court Nursing Center, Inc. v. Beal, supra,* held that no pre-termination hearing was required for the home as such. It so held after a detailed analysis of *Mathews v. Eldridge,* 424 U.S. 319, which is persuasive. Thus the court in *Town Court* concluded in the opinion by the panel:

> "The opinion of the Supreme Court in *Mathews v. Eldridge, supra,* makes it apparent that due process does not require that Town Court be given an evidentiary hearing and judicial review prior to the effective date of the Secretary's initial decision to terminate provider status under Medicare."

Town Court, 586 F.2d 280 (3d Cir.) (en banc), went to the Supreme Court from the en banc consideration by the Third Circuit as to the residents only as the home did not seek a review of the decision by the Court of Appeals panel. *Klein v. Mathews,* 430 F. Supp. 1005 (D.N.J.), remanded at 586 F.2d 250 (3d Cir.), also concerned only the residents' rights. *Klein* was discussed at 586 F.2d 280.

In *Hathaway v. Mathews,* 546 F.2d 227 (7th Cir.), there was no process or proceedings afforded the nursing home before termination and reasons for termination were not made known to the provider. The state in *Hathaway* was of

the view that the home had complied with the regulations. These factors made the case distinguishable.

In *Case v. Weinberger,* 523 F.2d 602 (2d Cir.), the court decided that a pre-termination hearing for a provider was not required and gave particular emphasis to the fact that the nursing home is not the intended beneficiary of the Medicare program. It indicated that the fact that the particular home might not survive without Medicare patients was not a primary consideration and "the facility's need is incidential." Also the Second Circuit stated that the benefits to the home arose from an ordinary contractual business agreement with the government.

We must hold that a pre-termination hearing is not required as to the plaintiff Home herein and under *O'Bannon v. Town Court Nursing Center,* ____ U.S. ____, 48 U.S.L.W. 4842 (June 23, 1980), the residents of Eventide of Lakewood Nursing Home are not entitled to a pre-termination hearing.

The order and judgment of the District Court are reversed.

APPENDIX B

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO
Civil Action No. 79-W-1286

GERIATRICS, INC., *et al.*,	)	
	)	
Plaintiffs,	)	COURT'S
	)	RULING
PATRICIA HARRIS, *et al.*,	)	
	)	
Defendants.	)	

Proceedings before THE HONORABLE FRED. M. WINNER, Chief Judge, United States District Court for the District of Colorado, commencing at or about 8:00 a.m., Monday, October 22, 1979, and continuing thereafter, in Courtroom C502, United States Courthouse, Denver, Colorado.

APPEARANCES

FREDERICK MILES and RICHARD McMANUS, Attorneys at Law, appearing on behalf of Geriatrics, Inc.

RICHARD STUCKEY, Attorney at Law, appearing on behalf of the residents of Eventide Nursing Home.

WILLIAM C. DANKS, Assistant United States Attorney, appearing on behalf of the Federal Defendants.

HENRY SOLANO, Deputy Attorney General, appearing on behalf of the State of Colorado.

JAMES P. CULBRETH, Attorney at Law, appearing on behalf of certain Defendants.

PROCEEDINGS

3:20 p.m.

* * * *

THE COURT: Well, necessarily, in view of the manner in which these findings and conclusions are being made, a review of them later will disclose places where they could be improved upon, and I am confident that the grammar will be subject to a great deal of criticism because the spoken word for some reason never reads very well.

I have explained why I am deciding this case orally rather than writing. I do not deem it necessary to repeat that, and I will do the best I can to make findings which will meet the strict requirements of both Rule 52 and Rule 65.

Undeniably, much of what I am about to say is cribbed openly, notoriously, and without shame from the opinions of the Third Circuit. I take much of the discussion from the three cases which I deem to be controlling. The first, as you all know, is *Cline v. Califano,* a Third Circuit case in 586 F.2d 250. The second is *Town Court Nursing Center v. Beal* that was the appeal of the Secretary of the Department of Health, Education and Welfare. That's in 586 F.2d at page 266. And the third is *Town Court Nursing Center and Emma Cooper v. Beal.*

The three cases taken together, in my judgment, represent a complete cross section of the law which has been developed in this relatively new field and, in my judgment, they represent the best discussion of the controlling law.

I have been openly concerned because of some of the language in some of these cases, that it could be argued that the plaintiff, as this case was originally structured, did not have standing of a nature which would permit this case to proceed although, quite candidly, that is an area I disagree with the Third Circuit on. I think the *Seldon* Rule would be fully applicable here and that the plaintiff does have standing.

The Third Circuit never discussed that case and I don't have the citation to it but, nevertheless, I think it opens up a lot of eyes to the question of standing. That problem has been pretty well resolved ever since this morning when the petition to intervene was granted, and now we have the residents in the case and I am not the least bit concerned, then, about the ripeness of the controversy.

Because of the importance of this case, I should explain why I am proceeding by way of preliminary injunction rather than waiting. I find that there is only a likelihood of success at the time of the final hearing, but I find that there is a very strong probability of success at the time of final hearing. That is not to say that after a full record is developed, I may not change my mind, but at least for purpose of a preliminary injunction, I find that an adequate record has been made to convince me that after a full hearing I will remain of the firm conviction that the contracts here in question cannot be terminated without affording a hearing of some sort to the residents.

And as was pointed out to ably by the Third Circuit, an adequate hearing cannot be provided the residents without affording the plaintiffs in this case the opportunity to participate fully. It is true that in some respects the interests might be conflicting, but it is equally true that in many respects the interests are identical.

The residents are represented by an attorney of remarkably long experience in the federal court. He has long experience with the Department of Justice. He was the first Assistant United States Attorney. He is a lawyer for whom I and every other member of our court has a very high respect, and I'm not the least bit concerned that if the residents have any conflict with the plaintiff, that the interest of the residents will be fully and adequately protected. Therefore, I think it very appropriate that the matter proceed in its present structure.

The matters here involved have to do directly or indirectly with two public medical assistance programs, the

first is the Federal Health Insurance for the Aged and Disabled, and this program is commonly referred to as Medicare. Part "A" of Medicare provides for hospital insurance benefits for qualified beneficiaries, and it is totally federally funded and administered by the Secretary of Health, Education and Welfare. However, important administrative tasks under this program are delegated to and are performed by certain state agencies.

The other program is the Colorado program commonly called Medicaid. Insofar as I have been able to ascertain during the relatively short time available to me to inquire into it, there are not substantial differences between the Colorado Medicaid program and the Pennsylvania Medicaid program, and if there are any such differences of any magnitude, I am not aware of them.

The Colorado program is administered by the Department of Social Services while the Pennsylvania program was administered by the Secretary of Public Welfare in that state. Medicaid is funded jointly by the state and the federal government, but the federal government reimburses the state for a certain percentage of the cost of the state program, and to be eligible for that reimbursement, it is claimed that the Colorado Medicaid program must comply with requirements set out in the federal Medicaid statute, something I have a little trouble with; and it is further claimed that to be eligible for reimbursement, the Colorado program has to comply with all of the regulations promulgated by the Health, Education and Welfare.

I have serious reserved doubts as to the validity of some of those regulations, but I do not reach those at this time. The time to reach those is later, if necessary, but let me say that I do not want the federal government to operate under the dilusion that I am at this time approving the validity, constitutionally or otherwise, of all of the regulations.

Both of the two programs are designed to provide assistance to persons both needy and otherwise in some instances, and both programs provide for reimbursement for certain

nursing home facilities. The reimbursement is not made directly to the residents or to the patients, whichever term you may want to use, but it is made to the provider of services as reimbursement for the cost of serving eligible patients. The initial plaintiff here was a provider, and that is the structure of this lawsuit.

To qualify for reimbursements, it is necessary that the provider execute a provider agreement and under the Medicaid program that agreement runs as between the nursing home and HEW, while under the Medicaid program the agreement is between the nursing home and the state agency, which would here be the Colorado Department of Social Services.

It is necessary that the nursing home receive certain certifications under the applicable statute and regulations, and the programs are set up so that the determination that a nursing home is appropriately certified to participate under the programs, the certification controls the right to receive the funds.

The way the thing is structured, not only the federal government can do this — the way it is structured is that if a state is to participate in the Medicaid program, it has to say that the Medicaid plan provides that any nursing home receiving payments must satisfy certain requirements set up under the Medicaid program. Therefore, Colorado has to terminate any Medicaid provider agreement with a nursing home upon notificiation the Department of Health, Education and Welfare hasn't renewed or has terminated that nursing home's Medicaid provider agreement.

Moreover, Colorado's Medicaid statute independently says that reimbursement may be made only to nursing home facilities qualified to participate under Title 19 and, as I understand it, under both the state and the federal statutes, participation in Colorado's Medicaid system is contingent upon a facility such as plaintiff being certified under the federal Medicaid provisions.

To further confuse the matter, the Secretary of Health, Education and Welfare is responsible for determining whether a facility qualifies as a skilled nursing facility and, to carry out this responsibility, the Secretary is required to contract with an appropriate state agency to have that agency survey institutions seeking certification as skilled nursing facilities. As I've said, that's the Department of Social Services in Colorado.

Here, as was true in *Town Court*, number one, the decision has been made to terminate the plaintiff, and that's the way we reach this case with the decision made to terminate the plaintiff. Testimony has been taken in connection with a temporary restraining order which I issued and which has been extended, and which by stipulation is a part of the record in the case on this preliminary injunction.

More testimony has been taken today in connection with the preliminary injunction hearing. All of the medical testimony is to the effect there is transfer trauma which would be very or might be very, very damaging to the residents. I have heard no credible testimony to the contrary. I have heard some sociological testimony which left me completely unimpressed, and I find as a fact based upon the evidentiary record made that there is grave risk of transfer trauma and grave risk of emotional disturbance and grave risk of possible death if these residents are transferred.

I find that the decision to terminate has been made without a hearing and, that being true, then the question in the case really becomes this now: Can some bureaucrat interfere with the continued operation of this nursing home and with the continued residents in the nursing home by the person presently here without affording those residents or the nursing home any hearing?

I think not. I think there has to be some type of a hearing. I think that unless the Fifth Amendment is to be written out of the Constitution of the United States, that a hearing is absolutely required. The precise nature of the hearing, I'll get to later, but I have not the slightest doubt

that some type of hearing is absolutely required under the decisions of the United States Supreme Court.

Now this, of course, is founded upon the concept and it is a concept with which I totally agree, that the right of these individuals to reside in this nursing home, whether they be paying their own way or whether their way is being paid by relatives or whether they are residing here as a result of a governmental program, I think that is a property right. I think the *Board of Regents against Roth*, 408 U.S. 564, can be read no other way. That case, of course, involved a school teacher, but to me the right of an elderly person or a younger person, such as we have here today, to reside in a nursing home is at least as great as the right of a school teacher to teach in a particular school. The Fifth Amendment, as was said in *Roth*, does not create property rights, it protects property rights which are created or defined by other rules.

If I be wrong on my reading of *Board of Regents v. Roth*, I challenge the Department of Health, Education and Welfare to distinguish *Matthews v. Eldritch*, 424 U.S. 319. Because, as we all know, *Matthews v. Eldritch* had to do with, and there the Supreme Court explicitly recognized, that the continued receipt of federal Social Security — or social welfare benefits — constituted a property right.

Now, if it is a property right to receive welfare benefits, I openly challenge the Department of Health, Education and Welfare to explain to me why a person has a property right to receive welfare benefits but does not have a property right to receive Medicaid benefits. I challenge the Department of Health, Education and Welfare to distinguish *Goldburg v. Kelly*, 397 U.S. 254. If the courts in *Roth*, *Eldritch* and *Kelly* had jurisdiction, I am unimpressed with any agrument that this court does not have jurisdiction of this matter, and I totally reject any argument that the court is without jurisdication, especially after the intervention.

I have not the slightest difficulty in holding that the threatened conduct would deprive these residents of entitle-

ment to government benefits within the meaning of the Fifth Amendment. Clearly, the residents would be deprived of their right to reside here and, with equal clarity, the operators of this institution would be deprived of their right to continue to operate.

I have paraphrased here before, but I now quote directly from *Town Court* (I):

"The statutory provision permitting a recipient to obtain medical care from a freely selected provider and the regulations prescribing limited conditions for transferring the resident of a nursing home create a legitimate entitlement to continued residency at the home of one's choice as specific cause for transfer.

"Administrators are not given the power to arbitrarily transfer for any reason a Medicaid patient from one nursing home to another.

"Where statutory benefits may be discontinued only on the occurrence of specified reason or for cause, the existence of such reasons or cause may be established only after recipients of those benefits are given some form of hearing.

"The essence of due process is that legally generated expectations of continued receipt of government benefits may not be summarily denied by arbitrary administrative action.

"Notice and opportunity to be heard enable the recipient of government benefits to retain their benefits by proving to the administrative agency that specified reasons or causes for termination of benefits have not occurred. No one disputes that if a nursing care facility is to be determined to be an unqualified provider, then Medicaid patients may be transferred to other facilities. Such transfer would fall within the limited condition of the regulations permitting transfer for the welfare of the patient.

"Due process does not distrub this administrative role. Due process requires only that the Medicaid nursing patients ... given an opportunity to participate in the administrative process to determine whether transfer is for his or her welfare.

"Because a decision should decertify a nursing home as an unqualified provider is tantamount to an order to transfer a patient for his welfare, Medicaid residents threatened with transfer are entitled to some form of hearing on the existence of the condition or cause for transfer whether the home is a qualified provider and whether decertification is for the patient's welfare."

I have heard testimony in this case from which, as I've already said, I find that the physical and emotional welfare of these patients would be jeopardized by a transfer. I have heard testimony in this case which convinces me, at least for purposes of a preliminary injunction and subject to review on a full record being made — and, unfortunately, there is no testimony from the government on this aspect of the case. I think it would be helpful if it had been — but based on hearing only one side of the story, really, I find for purposes of this hearing that the action of the government was arbitrary and capricious and that it is unsupported and unsupportable.

I find that and I conclude that, some type of hearing must be held. There's not the slightest doubt in my mind but that a hearing is required under the requirements of the Fifth Amendment that persons not be deprived of property rights of due process of law.

There remains, of course, the ever recurring question of, even though there be a requirement for due process of law, what process is due? I do not think that there is any requirement for a full judicial type of hearing. I do not think that all of the discovery rules are fully applicable to this type of hearing, but I do think that a hearing is required which both sides and the residents may present their facts and at which

some administrative law judge can structure — and I leave it for him to structure — an adequate hearing.

As we know from the hearing on the temporary restraining order, the state administrative law judge is willing to move and move fast. The state administrative law judge is willing to conduct a joint hearing. At the time of the temporary restraining order, that concept was rejected by the federal government. Perhaps it can still be worked out.

If it will be any help, I'm absolutely convinced and I find that the conduct of two hearings as opposed to one hearing will be prejudicial to the physical and emotional health of the residents, and I find that irrespective of the niceties and the technicalities of the law, humanity and common decency demands a single hearing. Even though some sort of a legal argument could be made that it would be degrading to a federal administrative law judge to sit on the same bench with a state judge, I am going to ask that the federal people demean themselves just a little bit. After all, I have sat on the same bench with state judges and I found it to be a learning experience rather than a degrading experience.

If the administrative law judge or judges are unable to structure a hearing — they are better lawyers than I am — if they are unable to structure a hearing, you can come back and I'll detail it more, but I'm a great believer in the idea that a United States District Judge ought to stay out of it as much as he can stay out of it, and that's why I'm not — that's one of the reasons I am not formally finding anything concerning the merits or demerits out here.

I will say that I have heard not one word of testimony thus far to the effect that the conditions in this home presently are not conditions beneficial to the patients. If there ever is to be any such testimony before me, I suppose it would come at a later hearing but, in any event, I certainly have not heard testimony of that type to date, and based upon the record made in this case as of this time, I cannot see any basis for terminating this facility. But, as I say, I'm not passing on that. That's *obiter dictum*.

Now as I understand it, the *Town Court* case (II), may or may not be heard by the United States Supreme Court this term. If it is, lots of things may change. I do not totally agree with *Town Court* (II) on the right of the provider to a hearing. *Town Court* (II) proceeds upon the underlying concept that the provider has an adequate remedy at law; that may well be my conclusion if we ever get to a permanent injunction hearing but, for the moment, I think the scales weigh in favor of a conclusion for purposes of a preliminary injunction but the remedy at law is not adequate.

The testimony I've heard — and I grant you that is fragmentary — is to the effect that the patients themselves may have trouble finding another home but, indeed, if this place is cleaned out, and if an effort is made to start it again, I don't know how long it would be before the home could be filled and fully operable again. I've heard no testimony on that, but I fear this is somewhat like starting a rumor about the virtue of a man's wife, that once the rumor gets started it's hard to stop, and I think maybe the injury here may be irreparable.

I do not — yes, I do — like to disagree with the Court of Appeals. I shouldn't be so modest, I love to disagree with the Court of Appeals. But be that as it may, I do disagree with the Third Circuit on that point. I don't think the Third Circuit thought of it from that viewpoint.

I completely agree with the Third Circuit's decision in *Cline* in *Town Court* (I) and in *Town Court* (II), save and except for that one limited departure on my part from the rulings in those cases. I completely agree as to the standing questions, as to the right to a hearing, and as to all other aspects.

If I have failed to cover adequately, in these oral findings, any of those matters, all — you can't adopt by reference in these but, nevertheless, let me say that I just totally agree with those two long opinions save and except for that one point. I emphatically think that the residents have a right to a pre-termination hearing.

Accordingly, it is ordered that prior to termination of the funds, prior to termination of the reimbursement of the state, in accordance with the applicable contracts and regulations, the intervenors and the class they represent shall be given an opportunity for evidentiary hearings before an appropriate representative, presumably an administrative law judge, of the Department of Health, Education and Welfare, and before an appropriate state administrative law judge. That hearing shall review the decision that the plaintiff does not comply with the conditions of provider participation in the Medicaid program and with the decision to terminate federal funding direct and indirect to the plaintiffs.

The hearing rights available, although I do not delineate them in precise detail, shall be not less than those available to Medicaid recipients at hearings before state agencies held pursuant to appropriate federal regulations, and I believe that the appropriate regulation is 45 Code of Federal Regulations, Section 205.10.

The defendants are expressly enjoined from terminating federal financial participation for services rendered to the intervenors and the class they represent until the conclusion of the administrative hearings.

This being a preliminary injunction, I'm sure that it goes without saying that I do retain jurisdiction of the case in the event that is necessary. I would urge that the administrative hearings be expedited in every possible way, but all I can do is to urge that that be done. In the event that the defendants elect to appeal — and, of course, this does as of this time become an appealable order — I am going to want to have briefs as to whether I do or do not have any residual jurisdiction, and as to whether an administrative law judge does or does not have any residual jurisdiction.

Quite candidly, I don't know. If neither I nor the administrative judge retains residual jurisdiction after the notice of appeal be lodged, I think it entirely possible that both plaintiffs and the intervenors will urge that the appeal be taken because I think that would leave the preliminary

injunction in full force and effect until the United States Court of Appeals for the Tenth Circuit reviewed the case.

I will say that if the United States Court of Appeals reviews and reverses the case, I will, of course, study the opinion very carefully, but unless I am pretty clearly told not to go ahead with a permanent injunction hearing, the probabilities are I will go ahead with one of those at that time, and you can have two trips to the Court of Appeals.

I don't do that because I think the Court of Appeals needs the business, but that is going to be the result.

Now, I am going to ask Counsel if they can think of anything I've overlooked here which should be included for the protection of everyone.

MR. DANKS: Your Honor, the amount of bond.

THE COURT: Yes, I'll fix the amount of bond at $1,000, and I do that for this reason: The government isn't going to be out any money. They are going to have to come up with the money one place or another and the ultimate result of the government financially is exactly the same whether the people reside here or somewhere else. This is a case in which I think the popular concept on consumer litigation type cases is to the affect that no bond at all might be applied, but I don't do that.

Now, if you can demonstate to me where there is need for a larger bond, I'm willing to consider it but, as I view it, I'm unable to see why there should be a large bond, but I'm more than willing to take testimony on it or handle it any other way you wish.

MR. STUCKEY: In one of these *Town Court* cases, Your Honor — I can't put my finger on it, I don't have the opinions — I came across in one of the appendix that bond was $100.

THE COURT: Well, I'm going high. Now, if anybody has got any reason why they think a large bond is necessary, I'm willing to hear it. I don't perceive it.

MR. SOLANO: Your Honor, on behalf of the residents if Mr. Stuckey would make that argument, many of them being indigent and cannot come up with a bond, the state is not requiring that the residents come up with the bond.

THE COURT: I'm figuring the residents can't come up with a bond of a dol' r and a half, and I'm figuring the state doesn't have to come up with a bond, but I've got a solvent plaintiff here who can probably scrape up a thousand dollar bond and that ought to pay the costs.

MR. STUCKEY: Thank you, Mr. Solano. Your Honor, I have one question. Maybe Mr. McManus is about to ask it. Maybe I didn't hear your comments about agreeing with everything but the one point, but if you didn't agree in *Town Court,* I don't know if you meant to state in your order what I believe I heard you say, that the plaintiff intervenor in the class shall be given the right to an appropriate hearing, et cetera. I didn't know if you said plaintiff intervenor or —

THE COURT: I don't believe I covered that adequately.

MR. STUCKEY: I didn't know if you meant plaintiff and intervenor or plaintiff intervenor.

THE COURT: All right, let me cover that if it isn't clear. I think the intervenor class and the plaintiff are entitled to that hearing. Now, that as I read *Town Court* (II), would be the result even under *Town Court* (II) because, as I read the case, although it says that the nursing home wasn't in and of itself entitled to the hearing, it goes on to say that since the residents are entitled to the hearing, the nursing home can participate.

The only departure I've got is that I say that the nursing home can participate as a matter of right instead of as a right

derivative to the rights of the residents, but they're only going to get to participate once. They don't get to both open and close.

MR. STUCKEY: As a matter of information, if it helps the Court, I know from the attorneys, they have told me — "they" being the attorneys for *Town Court* in much as Mr. Miles' situation — have indicated that the attorney for *Town Court* has agreed in a perfunctory manner, and they are doing all the nuts and bolts of the hearing themselves. We'll solve that problem.

THE COURT: I don't want all those nice things I said to go to your head, Mr. Stuckey. The next time you come in I'll just give you fits. Well, Mr. Stuckey, I was afraid of that.

MR. MILES: I don't think you've been perfunctory thus far.

MR. STUCKEY: I don't have anything else.

THE COURT: Does anyone have anything else they can think of?

MR. DANKS: Does the Court want to set a date for the preliminary injunction?

THE COURT: Sure, as soon as we get an answer I'll expedite the case in every way, but I want the answer in and if there are to be claims and crossclaims, I want them filed in accordance with the Rules of Civil Procedure; and if there are going to be replies to counterclaims and answers to crossclaims, I want those in.

Then I want the pretrial conference and away we go. And I want some estimate of the length of time that would be required for the trial, but I'll expedite it in every way.

As I view it, the next step is up to you to answer.

MR. DANKS: Is the injunction applied to any patients — Medicaid patients — who entered the facility after August 1 and after today's date, or what is that?

THE COURT: I don't know, I think that has been adequately briefed, but I would think it probably would. I see no reason it shouldn't. If the termination was ineffective, it was ineffective, and although they might not be proper parties plaintiff, I don't know. But the termination, heavens, you cannot just partially terminate somebody.

MR. DANKS: I'm talking about people that haven't even arrived at this institution. Do they have a property right here?

THE COURT: Of course not yet.

MR. SOLANO: Your Honor, I think just as a point of clarification, because one of the state notices as a matter of custom indicated and procedure indicated that whatever action was to be taken, one of which was no new admission of residents because of the state of flux.

THE COURT: As far as I'm concerned they can admit new residents and, if Mr. Danks wants to, a supplemental complaint can be filed for each resident, and I strongly suspect that each new resident will get exactly the same result.

I do that for a practical reason. The operation of a facility such as this necessarily involves people leaving, either because of death or because of a need to go to a hospital or because of other reasons, and you cannot expect a facility such as this to operate at half steam. The overhead goes on. And I think it would be — I think it would be detrimental to the remaining residents if we put the institution in the position that we were cutting down on the gross income. That's what happened to Chrysler, and look where they are.

No, I think, technically, they're not covered by the present complaint, but I'll permit supplemental complaints to be

filed, if necessary, every time. I think it's going through — I think that's paying a lot of work service to form.

MR. SOLANO: The main thing, Your Honor, was just so I could adequately advise having a letter go out to all parties in the state perspective because if, indeed, that becomes an issue, we would wish to crossclaim for any additional monies on behalf of everyone that later comes in.

THE COURT: I think you should. I think you should crossclaim everybody.

MR. SOLANO: Your Honor, in this matter, since as I read the rules, our crossclaim was due at the same time as our answer —

THE COURT: You need more time.

MR. SOLANO: Well, we have filed it, it's just, I think, upon court order any additional basis under 18(a) that we might join with the crossclaim would be permissible.

THE COURT: You just tender an order and I'll sign it. You may have any order you want on that. I want to wrap this whole thing up on one hearing, if possible. And that applies to everybody.

And then as soon as we get the case appropriately at issue, we'll structure it for a pretrial and go from there. Now, do any of you need anything else?

MR. SOLANO: Nothing further from the state.

MR. MILES: Defendants will waive service of notice on the preliminary injunction?

MR. SOLANO: Yes.

MR. DANKS: Yes.

MR. MILES: Nothing further on behalf of the plaintiff, Your Honor.

THE COURT: Okay, let's get the case going.

MR. STUCKEY: Thank you, Your Honor.

(And at 4:12 p.m., these proceedings were concluded.)

* * * *

REPORTER'S CERTIFICATE

I, ROBBIE GRIGGS, Certified Shorthand Reporter and Official Reporter to this Court, do hereby certify that I was present at and reported in shorthand the proceedings in the foregoing matter; that thereafter my shorthand notes were reduced to typewritten form under my supervision, comprising the foregoing official transcript; further, that the foregoing officical transcript is a full and accurate record of the proceedings in this matter on the date set forth.

DATED at Denver, Colorado, this 29th day of October, 1979.

Robbie Griggs
Official Reporter

APPENDIX C

JANUARY TERM - March 9, 1981

Before Honorable Oliver Seth, Chief Judge, Honorable David T. Lewis, Honorable William J. Holloway, Jr., Honorable Robert H. McWilliams, Honorable James E. Barrett, Honorable William E. Doyle, Honorable Monroe G. McKay, Honorable James K. Logan, and Honorable Stephanie K. Seymour, Circuit Judges.

GERIATRICS, INC., d/b/a EVENTIDE OF LAKEWOOD NURSING HOME,	)	
Plaintiff-Appellee,	)	
RUBY ARNOLD, et al.,	)	
Plaintiffs-Intervenors-Appellees,	)	
v.	)	No. 79-2317
PATRICIA HARRIS, et al.,	)	
Defendants-Appellants,	)	
COLORADO STATE DEPARTMENT OF HEALTH, et al.,	)	
Defendants-Cross Claimants-Appellees.	)	

This matter comes on for consideration of appellee's petition for rehearing and suggestion for rehearing in banc in the captioned cause.

Upon consideration whereof, the petition for rehearing is denied by the panel to whom the case was argued and submitted.

The petition for rehearing having been denied by the panel to whom the case was argued and submitted, and no member of the panel nor judge in regular active service on the Court be polled on rehearing in banc, Rule 35, Federal Rules of Appellate Procedure, the suggestion for rehearing in banc is denied.

HOWARD K. PHILLIPS
Clerk

APPENDIX D

STATUTORY AND REGULATORY PROVISIONS INVOLVED

* * *

42 U.S.C. (1976 & Supp. III, 1979)

§ 1395a. Free choice by patient guaranteed

Any individual entitled to insurance benefits under this subchapter may obtain health services from any instituiton, agency, or person qualified to participate under this subchapter if such institution, agency, or person undertakes to provide him such services.

* * *

§ 1395x. Definitions

For purposes of this subchapter.

* * *

(j) Skilled nursing facility

The term "skilled nursing facility" means (except for purposes of subsection (a)(2) of this section) an institution (or a distinct part of an institution) which has in effect a transfer agreement (meeting the requirements of subsection (l) of this section) with one or more hospitals having agreements in effect under section 1395cc of this title and which—

(1) is primarily engaged in providing to in-patients (A) skilled nursing care and related services for patients who require medical or nursing care, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

(2) has policies, which are developed with the advice of (and with provision of review of such policies from time to time by) a group of professional personnel, including one or more physicians and one or more registered professional nurses, to govern the skilled nurs-

ing care and related medical or other services it provides;

(3) has a physician, a registered professional nurse, or a medical staff responsible for the execution of such policies;

(4)(A) has a requirement that the health care of every patient must be under the supervision of a physician, and (B) provides for having a physician available to furnish necessary medical care in case of emergency;

(5) maintains clinical records on all patients;

(6) provides 24 hour nursing service which is sufficient to meet nursing needs in accordance with the policies developed as provided in paragraph (2), and has at least one registered professional nurse employed full time;

(7) provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals;

(8) has in effect a utilization review plan which meets the requirements of subsection (k) of this section;

(9) in the case of an institution in any State in which State or applicable local law provides for the licensing of institutions of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing institutions of this nature, as meeting the standards established for such licensing;

(10) has in effect an overall plan and budget that meets the requirements of subsection (z) of this section;

(11) complies with the requirements of section 1320a-3 of this title;

(12) cooperates in an effective program which provides for a regular program of independent medical evaluation and audit of the patients in the facility to the extent required by the programs in which the facility participates (including medical evaluation of each patient's need for skilled nursing facility care);

(13) meets such provisions of the Life Safety Code of the National Fire Protection Association (23d edition, 1973) as are applicable to nursing homes; except that the Secretary may waive, for such periods as he deems

appropriate, specific provisions of such Code which if rigidly applied would result in unreasonable hardship upon a nursing home, but only if such waiver will not adversely affect the health and safety of the patients; except that the provisions of such Code shall not apply in any State if the Secretary finds that in such State there is in effect a fire and safety code, imposed by State law, which adequately protects patients in nursing facilities;

(14) establishes and maintains a system that (A) assures a full and complete accounting of its patients' personal funds, and (B) includes the use of such separate account for such funds as will preclude any commingling of such funds with facility funds or with the funds of any person other than another such patient; and

(15) meets such other conditions relating to the health and safety of individuals who are furnished services in such institution or relating to the physical facilities thereof as the Secretary may find necessary (subject to the second sentence of section 1395z of this title), except that the Secretary shall not require as a condition of participation that medical social services be furnished in any such institution. Notwithstanding any other provision of law, all information concerning skilled nursing facilities required by this subsection to be filed with the Secretary shall be made available to Federal or State employees for purposes consistent with the effective administration of programs established under subchapters XVIII and XIX of this chapter; except that such term shall not (other than for purposes of subsection (a)(2) of this section) include any institution which is primarily for the care and treatment of mental diseases or tuberculosis. For purposes of subsection (a)(2) of this section, such term includes any institution which meets the requirements of paragraph (1) of this subsection. The term "skilled nursing facility" also includes an institution described in paragraph (1) of subsection (y) of this section, to the extent and subject to the limitations provided in such subsection. To the extent that paragraph (6) of this subsection may be deemed to require that any skilled nursing facility engage the

services of a registered professional nurse for more than 40 hours a week, the Secretary is authorized to waive such requirement if he finds that—

(A) such facility is located in a rural area and the supply of skilled nursing facility services in such an area is not sufficient to meet the needs of individuals residing therein.

(B) such facility has one full-time registered professional nurse who is regularly on duty at such facility 40 hours a week and

(C) such facility (i) has only patients whose physicians have indicated (through physicians' orders or admission notes) that each such patient does not require the services of a registered nurse or a physician for a 48-hour period, or (ii) has made arrangements for a registered professional nurse or a physician to spend such time at such facility as may be indicated as necessary by the physician to provide necessary skilled nursing services on days when the regular full time registered professional nurse is not on duty.

* * *

§ 1395aa. Agreements with States

(a) Use of State agencies to determine compliance by providers of services with conditions of participation

The Secretary shall make an agreement with any State which is able and willing to do so under which the services of the State health agency or other appropriate State agency (or the appropriate local agencies) will be utilized by him for the purpose of determining whether an institution therein is a hospital or skilled nursing facility, or whether an agency therein is a home health agency, or whether a facility therein is a rural health clinic as defined in section 1395x(aa)(2) of this title, or whether a laboratory meets the requirements of paragraphs (10) and (11) of section 1395x(s) of this title, or whether a clinic, rehabilitation agency, or public health agency meets the requirements of subparagraph (A) or (B),

as the case may be, of section 1395x(p)(4) of this title. To the extent that the Secretary finds it appropriate, an institution or agency which such a State (or local) agency certifies is a hospital, skilled nursing facility, rural health clinic, or home health agency (as those terms are defined in section 1395x of this title) may be treated as such by the Secretary. Any State agency which has such an agreement may (subject to approval of the Secretary) furnish to a skilled nursing facility, after proper request by such facility, such specialized consultative services (which such agency is able and willing to furnish in a manner satisfactory to the Secretary) as such facility may need to meet one or more of the conditions specified in section 1395x(j) of this title. Any such services furnished by a State agency shall be deemed to have been furnished pursuant to such agreement. Within 90 days following the completion of each survey of any health care facility, rural health clinic, laboratory, clinic, agency, or organization by the appropriate State or local agency described in the first sentence of this subsection, the Secretary shall make public in readily available form and place the pertinent findings of each such survey relating to the compliance of each such health care facility, rural health clinic, laboratory, clinic, agency or organization with (1) the statutory conditions of participation imposed under this subchapter and (2) the major additional conditions which the Secretary finds necessary in the interest of health and safety of individuals who are furnished care or services by any such health care facility, rural health clinic, laboratory, clinic, agency, or organization.

* * *

§ 1395cc. - Agreements with providers of services

* * *

(b) Termination of agreements

An agreement with the Secretary under this section may be terminated (and in the case of a skilled nursing facility, prior to the end of the term specified in subsection (a)(1) of this section)—

(1) by the provider of services at such time and upon such notice to the Secretary and the public as may be provided in regulations, except that notice of more than 6 months shall not be required, or

(2) by the Secretary at such time and upon such reasonable notice to the provider of services and the public as may be specified in regulations, but only after the Secretary has determined (A) that such provider of services is not complying substantially with the provisions of such agreement, or with the provisions of this subchapter and regulations thereunder, or (B) that such provider of services no longer substantially meets the applicable provisions of section 1395x of this title, or (C) that such provider of services has failed (i) to provide such information as the Secretary finds necessary to determine whether payments are or were due under this subchapter and the amounts thereof, or has refused to permit such examination of its fiscal and other records by or on behalf of the Secretary as may be necessary to verify such information, or (ii) to supply (within such period as may be specified by the Secretary in regulations) upon request specifically addressed to such provider by the Secretary (I) full and complete information as to the ownership of a subcontractor (as defined by the Secretary in regulations) with whom such provider has had, during the previous twelve months, business transactions in an aggregate amount in excess of $25,000, and (II) full and complete information as to any significant business transactions (as defined by the Secretary in regulations), occurring during the five-year period ending on the date of such request, between such provider and any wholly owned supplier or between such provider and any subcontractor, or (D) that such provider has made, or caused to be made, any false statement or representation of a material fact for use in an application for payment under this subchapter or for use in determining the right to a payment under this subchapter, or (E) that such provider has submitted, or caused to be submitted, request for payment under this subchapter of amounts for rendering services substantially in excess of the costs incurred by such provider for render-

ing such services, or (F) that such provider has furnished services or supplies which are determined by the Secretary to be substantially in excess of the needs of individuals or to be of a quality which fails to meet professionally recognized standards of health care, or (G) that such provider (at the time the agreement was entered into) did not fully and accurately make any disclosure required of it by section 1320a-5(a) of this title.

Any termination shall be applicable —

(3) in the case of inpatient hospital services (including tuberculosis hospital services and inpatient psychiatric hospital services) or post-hospital extended care services, with respect to services furnished after the effective date of such termination, except that payment may be made for up to thirty days with respect to inpatient institutional services furnished to any eligible individual who was admitted to such institution prior to the effective date of such termination.

(4)(A) with respect to home health services furnished to an individual under a plan therefore established on or after the effective date of such termination, or (B) if a plan is established before such effective date, with respect to such services furnished to such individual after the calendar year in which such termination is effective, and

(5) with respect to any other items and services furnished on or after the effective date of such termination.

* * *

§ 1395ff. Determinations of Secretary

* * *

(c) Appeal by institution or agencies

Any institution or agency dissatisfied with any determination by the Secretary that it is not a provider of ser-

vices, or with any determination described in section 1395cc(b)(2) of this title, shall be entitled to a hearing thereon by the Secretary (after reasonable notice and opportunity for hearing) to the same extent as is provided in section 405(b) of this title, and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.

* * *

§ 1396a. State plans for medical assistance

(a) Contents

A state plan for medical assistance must —

* * *

(9) provide —

(A) that the State health agency, or other appropriate State medical agency (whichever is utilized by the Secretary for the purpose specified in the first sentence of section 1395aa(a) of this title, shall be responsible for establishing and maintaining health standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services, and

(B) for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards, other than those relating to health, for such institutions;

* * *

(23) except in the case of Puerto Rico, the Virgin Islands, and Guam, provide that any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who

undertakes to provide him such services; and a State plan shall not be deemed to be out of compliance with the requirements of this paragraph or paragraph (1) or (10) solely by reason of the fact that the State (or any political subdivision thereof) has entered into a contract with an organization which has agreed to provide care and services in addition to those offered under the State's plan to individuals eligible for medical assistance who reside in the geographic area served by such organization and who elect to obtain such care and services from such organization, or by reason of the fact that the plan provides for payment for rural health clinic services only if those services are provided by a rural health clinic;

* * *

(28) provide that any skilled nursing facility receiving payments under such plan must satisfy all of the requirements contained in section 1395x(j) of this title, except that the exclusion contained therein with respect to institutions which are primarily for the care and treatment of mental diseases and tuberculosis shall not apply for purposes of this subchapter.

* * *

§ 1396d. Definitions

For purposes of this subchapter —

(a) Medical assistance

The term "medical assistance" means payment of part or all of the cost of the following care and services (if provided in or after the third month before the month in which the recipient makes application for assistance) for individuals, and, with respect to physicians' or dentists' services, at the option of the State, to individuals (other than individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in

amount, duration, and scope to the medical assistance made available to individuals described in section 1396a(a)(10)(A) of this title) not receiving aid or assistance under any plan of the State approved under subchapter IX, XIV, or XVI, or part A of subchapter IV, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter, who are —

(i) under the age of 21,

(ii) relatives specified in section 606(b)(1) of this title with whom a child is living if such child, except for section 606a(2) of this title, is (or would, if needy, be) a dependent child under part A of subchapter IV of this chapter,

(iii) 65 years of age or older,

(iv) blind, with respect to States eligible to participate in the State plan program established under subchapter XVI of this chapter,

(v) 18 years of age or older and permanently and totally disabled, with respect to States eligible to participate in the State plan program established under subchapter XVI of this chapter,

(vi) persons essential (as described in the second sentence of this subsection) to individuals receiving aid or assistance under State plans approved under subchapter I, X, XIV, or XVI of this chapter, or

(vii) blind or disabled as defined in section 1382c of this title, with respect to States not eligible to participate in the State plan program established under subchapter XVI of this chapter.

but whose income and resources are insufficient to meet all of such costs —

* * *

(15) intermediate care facility services (other than such services in an institution for tuberculosis or mental diseases) for individuals who are determined, in accordance with section 1396a(a)(31)(A) of this title, to be in need of such care;

* * *

(c) Intermediate care facility

For purposes of this subchapter the term "intermediate care facility" means an institution which (1) is licensed under State law to provide, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities, (2) meets such standards prescribed by the Secretary as he finds appropriate for the proper provision of such care, (3) meets such standards of safety and sanitation as are established under regulation of the Secretary in addition to those applicable to nursing facilities under State law, and (4) meets the requirements of section 1395x(j)(14) of this title with respect to protection of patients' personal funds. The term "intermediate care facility" also includes any skilled nursing facility or hospital which meets the requirements of the proceeding sentence. The term "intermediate care facility" also includes a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts, but only with respect to institutional services deemed appropriate by the State. The term "intermediate care facility" also includes any institution which is located in a State or an Indian reservation and is certified by the Secretary as meeting the requirements of clauses (2), (3), and (4) of this subsection and providing the care and services required under clauses (1). With respect to services furnished to individuals under age 65, the term "intermediate care facility" shall not include, except as provided in subsection (d) of this section, any public institution or distinct part thereof for mental diseases or mental defects.

ALTERNATIVE TO DECERTIFICATION OF LONG TERM CARE FACILITIES OUT OF COMPLIANCE WITH CONDITIONS OF PARTICIPATION; LOOK BEHIND AUTHORITY

Sec. 916. (a) Section 1866 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"(f)(1) Where the Secretary determines that a skilled nursing facility which has filed an agreement pursuant to subsection (a)(1) or which has been certified for participation in a plan approved under title XIX no longer substantially meets the provisions of section 1861(j), and further determines that the facility's deficiences —

"(A) immediately jeopardize the health and safety of its patients, the Secretary shall provide for the termination of the agreement or of the certification of the facility and shall provide, or

"(B) do not immediately jeopardize the health and safety of its patients, the Secretary may, in lieu of terminating the agreement or certification of the facility, provide

that no payment shall be made under this title (and order a state agency established or designated pursuant to section 1902(a)(5) of this Act to administer or supervise the administration of the State plan under title XIX of this Act to deny payment under such title XIX) with respect to any individual admitted to such facility after a date specified by him.

"(2) The Secretary shall not make such a decision with respect to a facility until such facility has had a reasonable opportunity, following the intial determination that it no longer substantially meets the provisions of section 1861(j),

to correct its deficiences, and, following this period, has been given reasonable notice and opportunity for a hearing.

"(3) The Secretary's decision to deny payment may be made effective only after such notice to the public and to the facility as may be prescribed in regulations, and its effectiveness shall terminate (A) when the Secretary finds that the facility is in substantial compliance (or is making good faith efforts to achieve substantial compliance) with the provisions of section 1861(j), or (B) in the case described in paragraph (1)(B), with the end of the eleventh month following the month such decision is made effective, whichever occurs first. If a facility to which clause (B) of the previous sentence applies still fails to substantially meet the provisions of section 1861(j) on the date specified in such clause, the Secretary shall terminate such facility's agreement or provide for termination of such facility's certification, notwithstanding the provisions of paragraph (2) of subsection (b), effective with the first day of the first month following the month specified in such clause."

(b)(1)(A) Section 1902 of such Act is amended by adding after subsection (h) (added by section 902(b)(2) of this title) the following new subsection:

"(i)(1) In addition to any other authority under State law, where a State determines that a skilled nursing facility or intermediate care facility which is certified for participation under its plan no longer substantially meets the provisions of section 1861(j) or section 1905(c), respectively, and further determines that the facility's deficiencies —

"(A) immediately jeopardize the health and safety of its patients, the State shall provide for termination of the facility's certification for participation under the plan and may provide, or

"(B) do not immediately jeopardize the health and safety of its patients, the State may, in lieu of providing for terminating the facility's certification for participation under the plan, provide

that no payment will be made under the State plan with respect to any individual admitted to such facility after a date specified by the State.

"(2) The State shall not make such a decision with respect to a facility until the facility has had a reasonable opportunity, following the initial determination that it no longer substantially meets the provisions of section 1861(j) or section 1905(c) (as the case may be), to correct its deficiences, and, following this period, has been given reasonable notice and opportunity for a hearing.

"(3) The State's decision to deny payment may be made effective only after such notice to the public and to the facility as may be provided for by the State, and its effectiveness shall terminate (A) when the State finds that the facility is in substantial compliance (or is making good faith efforts to achieve substantial compliance) with the provisions of section 1861(j) or section 1905(c) (as the case may be), or (B) in the case described in paragraph (1)(B), with the end of the eleventh month following the month such decision is made effective, whichever occurs first. If a facility to which clause (B) of the previous sentence applies still fails to substantially meet the provisions of the respective section on the date specified in such clause, the State shall terminate such facility's certification for participation under the plan effective with the first day of the first month following the month specified in such clause."

(B) Such section is further amended by inserting before the semi-colon at the end of subsection (a)(33)(B) the following: ", except that, if the Secretary has cause to question the adequacy of such determinations, the Secretary is authorized to validate State determinations and, on that basis, make independent and binding determinations concerning the extent to which individual institutions and agencies meet the requirements for participation."

(2) Section 1910 of such Act is amended by adding at the end thereof the following new subsection:

"(c)(1) The Secretary may cancel approval of any skilled nursing or intermediate care facility at any time if he finds on the basis of a determination made by him as provided in section 1902(a)(33)(B) that a facility fails to meet the requirements contained in section 1902(a)(28) or section 1905(c), or if he finds grounds for termination of his agreement with the facility pursuant to section 1866(b). In that event the Secretary shall notify the State agency and the skilled nursing facility or intermediate care facility that approval of eligibility of the facility to participate in the programs established by this title and title XVIII shall be terminated at a time specified by the Secretary. The approval of eligibility of any such facility to participate in such programs may not be reinstated unless the Secretary finds that the reason for termination has been removed and there is reasonable assurance that it will not recur.

"(2) Any skilled nursing facility or intermediate care facility which is dissatisfied with a determination by the Secretary that it no longer qualifies as a skilled nursing facility or intermediate care facility for purposes of this title, shall be entitled to a hearing by the Secretary to the same extent as is provided in section 205(b) and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g). Any agreement between such facility and the State agency shall remain in effect until the period for filing a request for a hearing has expired or, if a request has been filed, until a decision has been made by the Secretary; except that the agreement shall not be extended if the Secretary makes a written determination, specifying the reasons therefor, that the continuation of provider status constitutes an immediate and serious threat to the health and safety of patients, and the Secretary certifies that the facility has been notified of its deficiencies and has failed to correct them."

COLO. REV. STAT. 1973, as amended (1980 Supp.)

* * *

24-4-104. Licenses - issuance, suspension or revocation, renewal.

* * *

(11) A limitation unless consented to by the applicant, on a license applied for shall be treated as a denial. A modification, unless consented to by the licensee, of a license already issued shall be treated as a revocation.

* * *

25-1-107. Powers and duties of the department. (1) The department has in addition to all other powers and duties imposed upon it by law, the following powers and duties:

* * *

(l)(I) To annually license and to establish and enforce standards for the operation of general hospitals, psychiatric hospitals, community clinics, rehablitation centers, convalescent centers, community mental health centers, facilities for the mentally retarded, habilitation centers for brain-damaged children, chiropractic centers and hospitals, maternity hospitals, nursing care facilities, intermediate care facilities, residential care facilities, the pilot project rehabilitative nursing facility, and other institutions of a like nature, except those wholly owned and operated by any governmental unit or agency. In establishing and enforcing such standards and in addition to the required announced inspections, the department shall, within available appropriations, make additional inspections without prior notice to the facility. Such inspections shall be made only during the hours of 7 a.m. to 7 p.m. The issuance, suspension, renewal, revocation, annulment, or modification of licenses shall be governed by the provisions of sections 24-4-104, C.R.S. 1973,

and 25-3-102. and all licenses shall bear the date of issue and cover a twelve-month period. Nothing contained in this paragraph (1) shall be construed to prevent the department from adopting and enforcing, with respect to projects for which federal assistance has been obtained or shall be requested, such higher standards as may be required by applicable federal laws or regulations of federal agencies responsible for the administration of such federal laws.

* * *

25-1-120. Nursing and intermediate care facilities - rights of patients. (1) The department shall require all skilled nursing facilities and intermediate care facilities to adopt and make public a statement of the rights and responsibilities of the patients who are receiving treatment in such facilities and to treat their patients in accordance with the provisions of said statement. The statement shall ensure each patient the following:

(a) The right to civil and religious liberties, including knowledge of available choices and the right to independent personal decisions, which will not be infringed upon, and the right to encouragement and assistance from the staff of the facility in the fullest possible exercise of these rights;

(b) The right to have private and unrestricted communications with any person of his choice;

(c) The right to present grievances on behalf of himself or others to the facility's staff or administrator, to governmental officials, or to any other person, without fear of reprisal, and to join with other patients or individuals within or outside of the facility to work for improvements in patient care;

(d) The right to manage his own financial affairs or to have a quarterly accounting of any financial transactions made in his behalf, should he delegate such responsibility to the facility for any period of time;

(e) The right to be fully informed, in writing, prior to or at the time of admission and during his stay, of services

available in the facility and of related charges, including charges for services not covered under medicare or medicaid or not covered by the basic per diem rate;

(f) The right to be adequately informed of his medical condition and proposed treatment, unless otherwise indicated by his physician, and to participate in the planning of all medical treatment, including the right to refuse medication and treatment unless otherwise indicated by his physician, and to know the consequences of such actions;

(g) The right to receive adequate and appropriate health care consistent with established and recognized practice standards within the community and with skilled and intermediate nursing care facility rules and regulations as promulgated by the department;

(h) The right to have privacy in treatment and in caring for personal needs, confidentiality in the treatment of personal and medical records, and security in storing and using personal possessions;

(i) The right to be treated courteously, fairly, and with the fullest measure of dignity and to receive a written statement of the services provided by the facility, including those required to be offered on an as-needed basis;

(j) The right to be free from mental and physical abuse and from physical and chemical restraints, except those restraints initiated through the judgment of the professional staff for a specified and limited period of time or on the written authorization of a physician;

(k) The right to be transferred or discharged only for medical reasons or his welfare, or that of other patients or for nonpayment for his stay and the right to be given reasonable advance notice of any transfer or discharge, except in the case of an emergency as determined by the professional staff;

(l) The right to devolution of his rights and responsibilities upon a sponsor or guardian who shall see that he is

provided with adequate, appropriate, and respectful medical treatment and care and all rights which he is capable of exercising should he be determined to be incompetent pursuant to law and not be restored to legal capacity;

(m) The right to freedom of choice in selecting a health care facility;

(n) The right of copies of the facility's rules and regulations and an explanation of his responsibility to obey all reasonable rules and regulations of the facility and to respect the personal rights and private property of the other patients.

(2) Each skilled nursing facility or intermediate care facility shall provide a copy of the statement required by subsection (1) of this section to each patient or his guardian at or before the patient's admission to a facility and to each staff member of a facility. Each such facility shall prepare a written plan and provide appropriate staff training to implement the provisions of this section.

(3) Each skilled nursing facility or intermediate care facility shall prepare a written plan and provide appropriate facilities to ensure that the rights guaranteed by subsection (1) of this section are enforced by a grievance procedure which contains the following procedures and rights:

(a) A resident of any facility, the resident's advisory council, or the sibling, child, spouse, or parent of any resident may formally complain in the manner described in this subsection (3) about any conditions, treatment, or violations of his rights by the facility or its staff or about any treatment, conditions, or violations of the rights of any other resident, regardless of the consent of the victim of the alleged improper treatment, condition, or violation of rights by the facility or its staff.

(b) Each facility shall designate one full-time staff member, referred to in this subsection (3) as the "designee", to receive all grievances when they are first made.

(c) Each facility shall establish a grievance committee consisting of the chief administrator of the facility or his designee, a resident selected by the resident population of the facility, and a third person to be agreed upon by the administrator and the resident representative.

(d) If anyone designated in paragraph (a) of this subsection (3) wishes to complain about treatment, conditions, or violations of rights, he shall write or cause to be written his grievance or shall state it orally to the designee no later than fourteen days after the occurrence giving rise to the grievance. The designee shall confer with persons involved in the occurrence and with any other witnesses and, no later than three days after the grievance, give a written explanation of findings and proposed remedies, if any, to the complainant and to the aggrieved party, if someone other than the complainant. Where appropriate because of the mental or physical condition of the complainant or the aggrieved party, the written explanation shall be accompanied by an oral explanation.

(e) If the complainant or aggrieved party is dissatisfied with the findings and remedies or the implementation thereof, he may then make the same grievance orally or in writing, with any additional comments or information, to the grievance committee no later than ten days after the receipt of the explanation from the designee. Said committee shall confer with persons involved in the occurrence and with any other witnesses and, no later then ten days after the appeal from the designee, give a written explanation of its findings and proposed remedies, if any, to the complainant and to the aggrieved party, if someone other than the complainant. Where appropriate because of the mental or physical condition of the complainant or the aggrieved party, the written explanation shall be accompanied by an oral explanation.

(4) Each skilled nursing facility or intermediate care facility shall also establish a residents' advisory council which shall consist of not less than five members selected by and from the resident population of the facility. The council

shall meet at least once a month with the administrator of the facility and a representative of the staff to make recommendations concerning policies of the facility. The council may also present grievances to the grievance committee on behalf of a resident.

(5) If a complainant or aggrieved party is dissatisfied with the findings and remedies of the grievance committee or implementation thereof, except for grievances against a physician or his prescribed treatment, he may file the same grievance in writing with the executive director of the department. The department shall investigate the facts and circumstances of the grievance and make findings of fact, conclusions, and recommendations, copies of which shall be transmitted to the complainant and the nursing home administrator. If the complainant or the nursing home administrator is aggrieved by the findings and the recommendations of the department, the aggrieved party may request a hearing to be conducted by the department pursuant to section 24-4-105, C.R.S. 1973. The board shall adopt rules and regulations to carry out the intent of this section.

(6) Implementation of this section shall be pursuant to section 26-4-110 (5), C.R.S. 1973.

(7) Nothing in this section shall apply to any nursing institution conducted by or for the adherents of any well recognized church or religious denomination for the purpose of providing facilities for the care and treatment of the sick who depend exclusively upon spiritual means through prayer for healing in the practice of the religion of such church or denomination.

(8) A patient who is eligible to receive medicaid benefits pursuant to article 4 of title 26, C.R.S. 1973, and who qualifies for skilled or intermediate nursing care shall have the right to select any skilled or intermediate nursing care facility certified by the department of health under Title XIX of the social security act as a provider of medicaid services and licensed by the department pursuant to article 3 of this title

where space is available, and the department of social services shall reimburse the selected facility for services pursuant to section 26-4-110(5), C.R.S. 1973, unless such nursing care facility shall have been notified by the department of social services at the time of or prior to action on its application for certificate of public necessity that it may not qualify as a provider of medicaid services.

* * *

25-3-103. License denial or revocation - provisional license.

* * *

(4) No application for renewal of a license shall be denied by the department of health and no previously issued license shall be revoked, suspended, annulled, limited, or modified until after a hearing as provided in section 24-4-105. C.R.S. 1973.

* * *

26-1-109. Cooperation with federal government - grants-in-aid. (1) The state department shall be the sole state agency for administering the state plans for "public assistance and welfare", which term, as used in his title, includes but is not limited to assistance payments, food stamps, social services, health and medical assistance, child welfare services, rehabilitation, and programs for the aging in cooperation with the federal government, and any other state plan relating to such public assistance and welfare that requires state action which is not specifically the responsibility of some other state department, division, section, board, commission, or committee under the provisions of federal or state law.

42 C.F.R. (1980)

* * *

§ 405.1903 Documentation of findings

(a) The findings of the State agency with respect to each of the conditions of participation or conditions for coverage shall be adequately documented. Where the State agency certifies to the Secretary that a provider or supplier is not in compliance with the conditions, and therefore not eligible to participate in the program, such documentation includes, in addition to the description of the specific deficiencies which resulted in the agency's recommendation, a report of all consultation which has been undertaken in an effort to assist the provider or supplier to comply with the conditions, a report of the provider's or supplier's responses with respect to the consultation, and the State agency's assessment of the prospects for such improvements as to enable the provider or supplier to achieve compliance with the conditions within a reasonable period of time. (See § 405.1907.)

(b) If a provider or supplier is certified by the State agency as in compliance with the conditions or as meeting the requirements for special certification (see § 405.1910.) with deficiencies not adversly affecting the health and safety of patients, the following information will be incorporated into the finding:

(1) A statement of the deficiencies which were found, and

(2) A description of further action which is required to remove the deficiencies, and

(3) A time-phased plan of correction developed by the provider and supplier and concurred with by the State agency, and

(4) A scheduled time for a resurvey of the institution or agency to be conducted by the State agency within 90 days following the completion of the survey.

(c) If on the basis of the State certification, the Secretary determines that the provider or supplier is eligible to participate, the information described in paragraph (b) of this section will be incorporated into a notice of eligibility to the provider or supplier.

* * *

§ 405.1907 Providers or suppliers with deficiences

(a) If a provider or supplier is found to be deficient with respect to one or more of the standards in the conditions of participation or conditions for coverage, it may participate in or be covered under the Health Insurance for the Aged and Disabled Program only if the facility has submitted an acceptable plan of correction for achieving compliance within a reasonable period of time acceptable to the Secretary. The existing deficiencies noted either individually or in combination neither jeopardize the health and safety of patients nor are of such character as to seriously limit the providers capacity to render adequate care. (See § 405.1908 for special requirements applicable to skilled nursing facilities.)

(b) If it is determined during a survey that a provider or supplier is not in compliance with one or more of the standards it will be granted a reasonable time to achieve compliance. The amount of time will depend upon the nature of the deficiency and the State survey agency's judgment as to the capabilities of the facility to provide adequate and safe care. Ordinarily a provider or supplier will be expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies but the State survey agency may recommend that additional time be granted by the Secretary in individual situations, if in its judgment it is not reasonable to expect compliance within 60 days, e.g., a

facility must obtain the approval of its governing body, or engage in competitive bidding.

* * *

§ 431.153 Evidentiary hearing

* * *

(d) If a SNF is participating or seeking to participate, in both Medicare and Medicaid, and if the basis for the State's denial, termination or non-renewal of participation in Medicaid is also a basis for denial, termination or nonrenewal of participation in Medicare, the State must advise the facility that—

(1) The facility is entitled to the review procedures specified for Medicare facilities in Part 405, Subpart O of this title, in lieu of the procedures specified in this subpart; and

(2) A final decision entered under the Medicare review procedures will be binding for purposes of Medicaid participation.

* * *

§ 442.15 Duration of agreement.

(a) Except as specified under § 442.16, the duration of an agreement may not exceed 12 months.

(b) The agreement must be for the same duration as the certification period set by the survey agency. However, if the medicaid agency has adequate documentation showing good cause, it may make an agreement for less than this period.

(c) FFP is available for services provided by a facility for up to 30 days after its agreement expires or terminates under the conditions specified in § 441.11 of this subchapter.

* * *

§ 442.20 Additional requirements for agreements with SNF's participating in medicare.

* * *

(a) The medicaid agency's agreement with a SNF participating in medicare must—

(1) Provide for the same terms and conditions as medicare certification; and

(2) Be for the same duration as the medicare certification.

(b) If the Secretary notifies the Medicaid agency that he has denied, terminated or refused to renew a Medicare agreement with a SNF, the agency must deny, terminate, or refuse to renew its Medicaid agreement with that SNF. The denial, termination, or refusal to renew the Medicaid agreement must be effective on the same date as the denial, termination, or refusal to renew the Medicare agreement.

(c) If the medicaid agency has terminateed an agreement under paragraph (b) of this section, it may not make another agreement with that SNF until—

(1) The conditions causing the termination are removed; and

(2) The SNF provides reasonable assurance to the survey agency that the conditions will not recur.

* * *

§ 442.105 Certification with deficiencies: General provisions.

If a survey agency finds a facility deficient in meeting the standards specified under Subpart D, E, F, or G of this part, the agency may certify the facility for medicaid purposes under the following conditions:

(a) The agency finds that the facility's deficiencies, individually or in combination, do not jeopardize the patient's health and safety, nor seriously limit the facility's capacity to give adequate care. The agency must maintain a written justification of these findings.

(b) The agency finds acceptable the facility's written plan for correcting the deficiencies.

(c) If a facility was previously certified with a deficiency and has a different deficiency at the time of the next survey, the agency documents that the facility—

(1) Was unable to stay in compliance with the standard for reasons beyond its control, or despite intensive efforts to comply; and

(2) Is making the best use of its resources to furnish adequate care.

(d) If a facility has the same deficiency it had under the prior certification, the agency documents that the facility—

(1) Did achieve compliance with the standard at some time during the prior certification period;

(2) Made a good faith effort, as judged by the survey agency, to stay in compliance; and

(3) Again became out of compliance for reasons beyond its control.

(e) If an ICF or ICF/MR has a deficiency of the types specified in §§ 442.112 or 442.113 that requires a plan of correction extending beyond 12 months, the agency documents that the conditions of those sections are met.

§ 489.16 Nonrenewal agreements with SNFs.

* * *

(b) Notice of nonrenewal. (1) If HCFA decides not to renew an agreement with a SNF, it will notify the SNF at least 30 days, and the public at least 15 days, before the end of the term.

APPENDIX E

Senate Report No. 404, 89th Cong., 1st Sess., reported in [1965] U.S. Code Cong. & Admin. News, 89th Cong., 1st Sess. 1943, 1991-92-relating to Social Security Act Amendments of 1965, Public Law 89-97, effective July 30, 1965.

(3) Agreements to participate

An eligible hospital, extended care facility, or home health agency could participate in the programs if it filed with the Secretary an agreement not to charge any beneficiary for covered services for which payment would be made under the program and to make adequate provision for refund or erroneous charges. Of course, a provider could bill a beneficiary for deductible and coinsurance amounts, for the first 3 pints of blood furnished him during a spell of illness, and for the portion of the charge for a private room or services supplied at the patient's request and not paid for under the program.

An agreement could be terminated by either the provider of services of the Secretary of Health, Education and Welfare. Beneficiaries would be protected from an abrupt termination of an agreement by a provider by the requirement that notice must be given by the provider to the Secretary and to the public. The length of time between the notice and the point at which the termination becomes effective may be specified in regulations (but the length of time cannot be longer than 6 months).

The Secretary could terminate an agreement only after reasonable notice and only if the provider (a) does not comply with the provisions of the agreement or of the law and regulations, (b) is no longer eligible to participate, or (c) fails to provide data needed to determine what benefit amounts are payable or refuses access to financial records for verification of bills. The Secretary would be required to give reasonable notice and opportunity for hearing to a provider of services before making a final determination that the provider does

not qualify to participate under the program or before terminating an agreement with the provider. The final administrative decision is subject to judicial review.

APPENDIX F

House Report No. 96-1167, pages 55-58, reported in [1980] U.S. Code Cong. & Admin. News. 96th Cong., 2d Sess. 5526 5568-5571 relating to Section 916 of the Omnibus Reconciliation Act of 1980, Public Law 96-499, effective December 5, 1980.

ALTERNATIVE TO DECERTIFICATION OF LONG-TERM CARE FACILITIES OUT OF COMPLIANCE WITH CONDITIONS OF PARTICIPATION; LOOK BEHIND AUTHORITY (314)

The section authorizes the Secretary and State Medical agencies to deny reimbursement for services furnished by a skilled nursing facility (SNF) or an intermediate care facility (ICF) for all medicare and medicaid beneficiaries admitted to the facility after the date the Secretary determines that it is substantially out of compliance with the conditions of, or requirements for, participation. In the case of a facility with deficiencies that immediately jeopardize the health and safety of its patients, the bill requires the Secretary and the State agency to decertify the facility, and while decertification is underway, to deny reimbursement for medicare and medicaid patients admitted subsequent to the determination of noncompliance. In addition, the section authorizes the Secretary to "look behind" a State's survey of an SNF or ICF and, where the Secretary finds that a facility does not meet the conditions of, or requirements for, participation, to terminate the participation of the facility in medicare and medicaid.

At present, the only sanction available in many jurisdictions to penalize a skilled nursing facility which is out of compliance with the conditions of participation in the medicare and medical programs is to terminate that facility's participation in the program. Frequently, this sanction involves an overriding hardship to program beneficiaries which makes its use desirable, if not impossible.

In the case of facilities that are substantially out of compliance but do not have deficiencies that immediately jeopardize the health and safety of their patients, the section gives the Secretary authority to impose an intermediate sanction, short of the more drastic step of program termination. The Secretary would be expected to define by regulation the grounds for the imposition of an intermediate sanction. It is the expectation of the Committee that the existence of sanctionable deficiencies with the conditions of participation would generally be determined during the course of the formal State survey of the facility or HEW's compliance validation surveys. The denial of reimbursement for services furnished to medicare or medicaid beneficiaries admitted after a date designated by the Secretary would continue until such time as the deficiencies have been corrected or it is determined that good faith efforts to correct deficiencies are being made. This alternative sanction would be applicable for a limited period, not to exceed 12 months; thereafter, the bill would require the Secretary to decertify the facility.

In the case of facilities that are substantially out of compliance and have deficiencies that immediately jeopardize the health and safety of the patients, the section directs the Secretary or State agency to decertify the facility and, while the decertification process is underway, to deny reimbursement for any services furnished to medicare or medicaid beneficiaries admitted after a designated date. This additional sanction would be applicable for the duration of the decertification or termination proceeding.

Under the provision, a facility would have an opportunity to develop and implement a plan for correcting its deficiencies, in accordance with existing medicare policies on the correction of provider deficiencies. Following the facility's failure to satisfactorily meet this requirement, the Secretary could apply intermediate sanctions, but only after the Secretary has provided the facility with an opportunity to present its case at an informal hearing consistent with current practices. If the facility seeks further administrative or judicial appeals, the sanction would remain in effect while the appeals were pending.

(It should be noted that it is not the intention of the Committee that a decision to impose sanctions shall preclude whatever right to judicial review of disputes of fact concerning noncompliance with conditions of participation which a facility otherwise has.)

The Secretary would be required to provide public notification to potentially affected beneficiaries of the date the sanction takes effect and the fact that no benefits will be payable on behalf of a beneficiary admitted to the facility after that date. (Benefits would continue to be paid on behalf of beneficiaries who were inpatients of the facility prior to the designated date.) The Secretary would be required to promulgate regulations setting forth the procedures for implementing this provision.

The Committee believes that the application of this sanction, in lieu of immediate decertification of a facility where life and safety are not threatened, would serve to protect beneficiaries both by giving the skilled nursing facility an incentive to correct deficiencies in a timely manner and by forestalling the need for traumatic transfers of large numbers of patients during the time needed improvements are being made in the facility. However, the Committee believes that this sanction should not be used as an alternative in situations where a noncomplying facility's deficiencies place the health and safety of its patients in immediate jeopardy; instead, the response of the Secretary in such cases must be to deny all reimbursement of additional patients and to make appropriate arrangements for the orderly, planned transfer of existing patients.

It is recognized that several States presently have a full range of intermediate sanctions available, as part of their licensure authority, to impose against noncomplying facilities, including suspension of payments, bans on admissions, or even fines and penalties. The provision is not intended to limit or preempt such authority.

The section further authorizes the Secretary to make an independent and binding determination concerning the ex-

tent to which SNFs and ICFs that participate only in medicaid meet the requirements of participation in that program, and to terminate the eligibility of any facility that the Secretary finds does not comply with such requirements.

Under current law, the authority to determine whether an SNF or ICF that participates in medicaid but not medicare meets the requirements for participation in medicaid lies solely with the State medicaid agency. Based on current limited authority, the Secretary has issued regulations directed at assuring that States have followed Federal standards and norms in carrying out their survey and certification programs. However, the Committee is concerned that, without the authority to validate State agency compliance reviews and to make an independent judgment as to the extent of compliance by particular facilities, the Secretary lacks the means necessary to assure that Federal matching funds are being used to reimburse only those SNFs and ICF that actually comply with medicaid requirements.

The provision would accordingly provide the Secretary with the authority to "look behind" a State agency's compliance review of individual SNFs or ICFs. Where the Secretary determines that a facility has failed to meet the applicable requirements, then, the State agency's determination to the contrary notwithstanding, the Secretary would be authorized to terminate the facility's participation in medicaid until the reason for the termination is no longer present and there is reasonable assurance that it will not recur. Under the section, termination could not take effect until the affected facility had been provided an opportunity for a hearing on the Secretary's determination that it failed to meet the requirements for participation.

APPENDIX G

House Conference Report No. 96-1479, pages 140-41, reported in [1980] U.S. Code Cong, & Admin. News, 96th Cong., 2d Sess. 5903, 5931-5932 relating to Section 916 of the Omnibus Reconciliation Act of 1980, Public Law 96-499, effective December 5, 1980.

45. Alternative to decertification of long-term care facilities out of compliance with conditions of participation; look behind authority.

House bill. — The House bill authorizes the Secretary and State medicaid agencies to deny reimbursement for services furnished by a skilled nursing facility or an intermediate care facility for all medicare and medicaid beneficiaries admitted to the facility after the date the Secretary determines that such facility is substantially out of compliance with the conditions of participation. This intermediate sanction would be applicable as an alternative to decertification only in the case of a facility whose deficiencies do not immediately jeopardize the health and safety of patients; where patient health and safety is jeopardized, the Secretary and the State agency are required to take action to decertify the facility simultaneously with application of the more limited sanction. (The provision requires the Secretary to provide public notification to potentially affeted beneficiaries of the date of the sanction and the fact that no benefits will be payable on behalf of a beneficiary admitted to the facility after that date.) In addition, this provision authorizes the Secretary to "look behind" a State's survey of an SNF or ICF and, where the Secretary finds that a facility does not meet the conditions of participation, to terminate that facility's participation in medicaid.

Senate amendment. — No provision.

Conference agreement. — The conference agreement included the House provision with a modification limiting the Secretary's authority to "look behind" a State's survey of a

SNF or ICF to situations in which the Secretary has cause to question the adequacy of the State's determination: It is understood that cause for questioning the State's determination could include the general performance of the State system or complaints by residents, relatives, advocates or others about the quality of care or conditions in the facility. Under the Conference agreement it is intended that Federal financial participation could be continued with respect to medicaid patients of a facility decertified by the Secretary during such reasonable time as is required to effect the transfer of medicaid patients from the facility. Further, the conferees note that it is not the intention of this provision to alter the access to a full evidentiary hearing before decertification of a facility occurs, as provided under current law.

No. 80-2085

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CLERK

IN THE

SUPREME COURT OF THE UNITED STATES

October Term, 1980

GERIATRICS, INCORPORATED
doing business as
EVENTIDE OF LAKEWOOD NURSING HOME,
Petitioner,

vs.

RICHARD SCHWEIKER, Secretary of the United States Department of Health and Human Services,
DARREL MUHR, Regional Health Standards and Quality Director, United States Department of Health and Human Services,
COLORADO DEPARTMENT OF HEALTH
and
FRANK TRAYLOR, M.D.,
Executive Director of the Colorado Department of Health;
COLORADO DEPARTMENT OF SOCIAL SERVICES
and
ARMANDO ATENCIO, Executive Director of the Colorado Department of Social Services;
JEFFERSON COUNTY DEPARTMENT OF SOCIAL SERVICES
and
NELSON L. NADEAU, Director of the Jefferson County Department of Social Services;
and
STUART G. BARR, a Hearings Officer of the State of Colorado,
Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE TENTH CIRCUIT

BRIEF IN OPPOSITION

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INTRODUCTORY STATEMENT

The State of Colorado accepts the petitioner's statements regarding the parties, the decision below, jurisdiction and the pertinent constitutional, statutory and regulatory provisions.

QUESTIONS PRESENTED FOR REVIEW

1. Does a nursing facility have a property interest in its certification or its provider agreement under federal or state law?

2. If a property interest exists, must the facility be afforded an evidentiary administrative hearing prior to the termination of certification and reimbursement by the federal government pursuant to the medicare programs?

3. If a property interest exists, must the facility be afforded an evidentiary administrative hearing by the state government pursuant to medicaid statutes and regulations when, pursuant to federal regulations, a decision to decertify a nursing home is binding upon the state for purposes of medicaid?

4. Pursuant to Colorado law, is a provider agreement considered as an equivalent to a license?

SUPPLEMENTAL STATEMENT OF FACTS

The statement of the case offered by plaintiffs fails to fully set forth the factual circumstances material to the consideration of the questions presented. At the time that this case was heard on the motion for temporary restraining order, Geriatrics, Inc. owned, leased or operated approximately sixty-four nursing homes, including Eventide of Lakewood. Eventide's operating license, certification and its medicare and medicaid provider agreements were all due to expire in August 31, 1979. Pursuant to state and federal regulation, the Colorado Department of Health, as the desig-

nated survey agency, conducted a complete survey of Eventide on May 15 and 16, 1979. The purpose of the survey was to ascertain whether the certification, provider agreements and the state license to operate, should be renewed. The survey found several serious deficiencies in the areas of infection control and nursing services. These and other deficiencies were detailed in a thirty-seven page deficiency list. The deficiency list was furnished to Eventide, and Eventide responded with a proposed plan of correction. After reviewing the proposed plan of correction, and previous difficulties with the facility, the Colorado Department of Health notified Eventide by a letter dated July 27, 1979, that it did not intend to renew its license and certification and that it was recommending to the Department of Health and Human Service and the Colorado Department of Social Services that they refuse to renew Eventide's medicare and medicaid provider agreements, respectively.

On August 1, 1979, Health and Human Services notified Eventide that its medicare provider agreement would not be renewed. Pursuant to 42 C.F.R. 442.20 the state was required to terminate its medicaid provider agreements. On August 9, 1979 the Department of Social Services notified Eventide that it was not renewing its medicaid provider agreement. Geriatrics timely appealed these actions.

A hearing was set by the state on the matters of the license, medicaid certification and the provider agreement for August 27, 1979. A state hearing officer granted a stay with regard to the license and certification but refused a stay with regard to the provider agreement. As a result of the failure to continue the medicaid provider agreement, this action was commenced.

At the hearing on Eventide's motion for a temporary restraining order, David A. Kremser, then executive vice president in charge of finance for Geriatrics, Inc., testified that approximately 116 of the facility's 137 residents were receiving medicare. Mr. Kremser also testified that Geriatrics was losing $15,000 per month and that the potential loss of revenue if medicaid patients were removed was $37,000

per month. He also stated that Geriatrics, Inc. could continue to operate even if medicaid patients were removed from Eventide of Lakewood.

After evidence was heard, the trial court enjoined the agencies from terminating funding until a hearing was conducted to establish the status of the home's compliance with the pertinent regulations. He also ordered that the home be allowed to continue to admit medicaid and medicare patients.

In October 1980, the state and Geriatrics reached an agreement under which Geriatrics agreed to divest itself of the facility. Geriatrics relinquished the facility to a new owner, effective February 1981.

ARGUMENT

I.

THE QUESTION OF WHETHER A PRETERMINATION HEARING SHOULD BE GRANTED HAS BEEN ANSWERED BY THIS COURT.

This case is governed by *Board of Regents of State Colleges v. Roth*, 408 U.S. 564 (1972). The facts and analysis contained in *Board of Regents of State Colleges v. Roth* support Colorado's position that Geriatrics does not have a protectable property interest. In *Roth*, a teacher was hired as a non-tenured assistant professor at a Wisconsin university for a fixed term of one year. He completed the year but was not rehired for the following year. The university did not give a reason for its refusal to rehire, and it did not provide an opportunity for a hearing. This Court noted that the range of due process was not infinite and that to determine whether a property interest exists, the nature of the interest, rather than its weight, must be scrutinized. *Board of Regents v. Roth*, 408 U.S., at 571. Generally, the fifth and fourteenth amendments protect interests that a person has *already acquired*. *Board of Regents v. Roth*, 408 U.S., at 576. The court concluded that Roth's original appointment secured no interest in reemployment for the next year and that he did not have a property interest.

In this case, federal law limits provider agreements to one year. 42 U.S.C. 1395cc(a)(1); 42 C.F.R. section 442.15(a). In order to renew a provider agreement, a facility must be inspected annually to assure compliance with federal standards. 42 C.F.R. 442.12, (1980); 42 C.F.R. section 442.201 (1980) and 42 C.F.R. 456.606 (1980). A close reading of the federal law shows that there is no "already acquired" interest in renewal. The clear intent of limiting the provider agreement to one year is to terminate the contract, survey the facility to determine compliance with conditions of participation and to enter into a new agreement with the facility if the facility is in compliance with conditions of participation. Thus, Geriatrics does not have a property interest.

This Court has held that medicaid and medicare are entitlements for the patient. The entitlement belongs to the patient. The home, as a third party, has no privity to any constitutional or statutory due process rights that may accrue to its patients. *O'Bannon v. Town Court Nursing Center*, 447 U.S. 773, 786-790 (1980). Further, in *dictum*, the Court noted that a nursing facility does not have a right to a pretermination hearing by virtue of its provider agreement. *O'Bannon v. Town Court Nursing Center*, 447 U.S., at 785 fn 17. If the facility does not have an entitlement under either medicaid or medicare statutes or regulations, then it does not have a property interest.

Even assuming there is a property interest, this case is governed by *Mathews v. Eldridge*, 424 U.S. 319 (1976). In *Mathews*, the Court listed three factors that must be considered to determine whether there is a right to a pretermination hearing:

1. the private interest that will be affected by the official action;

2. the risk of erroneous deprivation of such interest through the procedure used and the probable value of additional safeguards;

3. the government's interest.

Clearly, the private interest herein is substantially less than for a physically disabled worker as is the hardship imposed by any erroneous deprivation. The facility does not have the same brutal need, and given the fact that Geriatrics owns sixty-four homes, it can hardly be said that one home will cause a significant hardship to the plaintiff. Finally, as noted in *O'Bannon*, the government has a significant interest in providing assurances of quality of care.

II.

NO REAL DIVISION EXISTS AMONG THE CIRCUITS WITH REGARD TO THE RIGHT TO A PRETERMINATION HEARING.

There is a commonality that runs through all of the cases cited by Geriatrics. All of the cases used a balancing test similar to that used in *Mathews v. Eldridge, supra.* All of the cases concluded that some process is due to a facility that is about to be decertified. None concluded that a pretermination hearing is due, where there are some procedural safeguards prior to the effective date of the action.

Geriatrics maintains that the tenth circuit's decision conflicts with decisions from other circuits. In its petition, Geriatrics intimates that the cited cases stand for the proposition that a pretermination hearing must be granted to providers. In fact, none of the cases, cited by Geriatrics supports its contention. The first case cited by Geriatrics is *Maxwell v. Wyman,* 458 F.2d 1146 (2d Cir. 1972). The underlying issue in *Maxwell* was whether a preliminary injunction should be issued pending a decision on whether New York State properly interpreted federal Life Safety Code waiver provisions. *Maxwell v. Wyman,* 458 F.2d at p. 1150. *Maxwell* cited three reasons for granting a pretermination hearing.

1. The Department of Social Services had misinterpreted federal law. Consequently its broad-based denial of waivers was an abuse of discretion.

2. Temporary waivers had been in effect for a period of time. It did not appear that there was imminent danger to the residents.

3. A change in federal regulations created substantial confusion.

Maxwell did state in *dictum* that ineligibility for a provider agreement "may make the state operating certificate,

concededly still outstanding useless." *Maxwell v. Wyman* at p. 1151. A later New York case specifically held that non-renewal of a provider agreement was not a limitation on an operating certificate. *Schwartzberg, et al. v. Whalen,* 66 A.D.2d 881, 411 N.Y.S.2d 667 (1978). The New York court, interpreting New York law, stated:

> Moreover, we hold that the termination of the Petitioners medicaid provider status is not a limitation of their operating certificate cognizable under section 2806 of the Public Health Law. The issuance of an operating certificate does not insure medicaid provider status. An operating certificate is merely a general license to conduct a nursing home. Separate Federal qualification must be met for provider status. Therefore, the State's refusal to renew the Medicaid provider agreement, pursuant to HEW's directions, cannot be equated with an actual limitation of the operating certificate for violations of Public Health Law. Consequently, no hearing is required.
>
> We note that the possible success of the limitation argument, which the Court in *Maxwell v. Wyman,* 2 Cir, 458 F2d 1146, 1151. Most cases cited were before *Mathews v. Eldridge,* speculated on, has *not been* borne out. Thus, the Petitioner's reliance is misplaced. *Schwartzberg v. Whalen,* 411 NYS 2d, at 668.

Thus, given the interpretation of the New York State court, *Maxwell v. Wyman* no longer retains any relevance or authority.

Geriatrics cites *Case v. Weinberger,* 523 F.2d 602 (2d Cir. 1977), in support of its contention that Geriatrics is entitled to a pretermination hearing. The conclusions drawn by Geriatrics from *Case* are incorrect. The Court did not hold that nursing facilities are generally entitled to a pretermination hearing; rather, it held that recipient should be entitled to a pretermination hearing. The *Case* court unequivocally found that the nursing facility interest was only incidental to the program and, at best, a business rela-

tionship. *Case v. Weinberger*, 523 F.2d at 607. The *Case* court did not deny a pretermination hearing because the conditions jeopardized the patients. *Case* stated that "(w)e need not decide here whether the conditions were so hazardous as to justify summary action." *Case v. Weinberger*, 523 F.2d at 607. Instead, it determined that no pretermination hearing was necessary because a sufficient review had occured.

Geriatrics also cites the case of *Hathaway v. Mathews*, 546 F.2d 226 (7th Cir. 1976). *Hathaway* is inapposite. In *Hathaway*, the facility received no notice of any proposed adverse action and did not have an opportunity to review the matter with any of the authorities prior to the proposed action. Compare to *Case v. Weinberger, supra*. The *Hathaway* court employed a balancing test and determined that, given the peculiar circumstances of the case, a pretermination hearing should be given.

Finally, Geriatrics cited *Caton Ridge Nursing Home v. Califano*, 447 F. Supp. 1222 (D. Md. 1978), *aff'd*, 596 F.2d 608 (4th Cir. 1979). All *Caton Ridge* stands for is the proposition that some process is due to a facility which is about to be decertified.

It is also important to note that the survey process is not significantly different from the process used to determine medical disability under Social Security as outlined in *Mathews v. Eldridge*. The standards are clearly set out in statute and regulation. Thus, even if there is a property interest, no pretermination hearing is required.

III.

THE PROVIDER AGREEMENT DOES NOT CREATE A DIRECT RELATIONSHIP BETWEEN THE PROVIDER AND THE GOVERNMENT.

The provider agreement is merely a device which the government generally uses to evidence that a nursing facility is qualified to care for medicare or medicaid patients. This is clearly stated in 42 C.F.R. 442.12-442.30. Geriatrics has not cited one federal statute or regulation which entitles it to more than a unilateral expectation of a property in-

terest. The fact that the provider agreements are limited to one year by statute and regulation and are subject to certification surveys conclusively prove that there was no more than unilateral expectation of a property interest.

Geriatrics cannot find support in Colorado law for its claim of a property interest. Colorado law denies property status to the provider agreement. C.R.S. 1973, 26-4-110(1) states:

> The state department shall establish rules and regulations for the payment of vendors under this article. Within limits of available funds, such rules and regulations shall provide reasonable compensation to such vendors, but no vendor shall, by this section or any other provision of this article, be deemed to have any vested right to act as a vendor under this article...

Thus, the state law argument, as presented by Geriatrics, is unfounded.

CONCLUSION

For the above stated reasons, the petition for writ of certiorari should be denied.

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In the Supreme Court of the United States

OCTOBER TERM, 1980

GERIATRICS, INC., d/b/a EVENTIDE OF LAKEWOOD NURSING HOME, PETITIONER

v.

RICHARD S. SCHWEIKER, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE TENTH CIRCUIT

MEMORANDUM FOR THE FEDERAL RESPONDENTS IN OPPOSITION

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ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE TENTH CIRCUIT

MEMORANDUM FOR THE FEDERAL RESPONDENTS IN OPPOSITION

Petitioner contends that a nursing home is entitled to an evidentiary hearing prior to implementation of the Secretary's decision not to renew the home's participation as a Medicaid and Medicare provider.

1. Petitioner is the owner of a nursing home that was authorized to provide government-funded health care services to Medicare and Medicaid recipients.[1]

[1] A health care facility may participate in the Medicare program by entering into a provider agreement with the Secretary of Health and Human Services after the Secretary certifies that the facility meets the requirements for a skilled nursing facility. 42 U.S.C. (& Supp. III) 1395cc; 42 C.F.R. Part. 405, Subpart S. The standards for skilled nursing facilities under the Medicare and Medicaid pro-

The home's license, certification, and provider agreements were due to expire, by their terms, on August 31, 1979 (Pet. 7). Prior to the expiration date, the nursing home applied for renewal. A certification inspection conducted by the Colorado Department of Health in May 1979 disclosed numerous violations of Medicare/Medicaid standards; the Department furnished the home with a 37-page report detailing these violations (Pet. App. 18). During several preceding years, inspectors had uncovered similar violations by the nursing home of federal and state standards governing Medicare/Medicaid health care providers (*ibid.*). Petitioner was given an opportunity to respond in writing to the inspection report (*ibid.*). Following receipt of petitioner's response, federal and state authorities notified petitioner of their initial decision to deny petitioner's renewal applications. Petitioner then pursued an administrative appeal of the state's action and requested that its authorizations be extended pending resolution of its administrative appeal (Pet. App. 19).[2] A state hear-

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grams are set out in 42 U.S.C. (& Supp. III) 1395x(j), 1396a(a)(28); 42 C.F.R. Part 405, Subpart K. A facility is deemed to meet the requirements for the Medicaid program if the Secretary has certified it for participation in the Medicare program. 42 U.S.C. (Supp. III) 1396i(a)(1); see 42 C.F.R. 442.20(a), (b). By agreement, the State of Colorado Department of Health performs the surveys necessary to determine whether facilities in that State meet the requirements for participation in the Medicare and Medicaid programs. See 42 U.S.C. (& Supp. III) 1395aa(a), 1396a(a)(33)(B); 42 C.F.R. 405.1902(c). The Colorado Department of Health also enforces state licensure laws governing health care facilities. Colo. Rev. Stat. § 25-1-107(1)(*l*)(I) (Cum. Supp. 1980).

[2] A determination that a provider agreement will not be renewed upon its expiration is an "initial determination" (42 C.F.R. 405.1502) from which a certified facility is en-

ing officer extended the state license and Medicaid certification, but refused to renew the Medicaid provider agreement pending the final administrative determination (*ibid.*). Accordingly, on August 31, 1979, petitioner's Medicare and Medicaid provider agreements lapsed (*ibid.*).

Thereafter, on September 17, 1979, petitioner filed this action in the United States District Court for the District of Colorado, seeking to enjoin the State of Colorado and the Secretary from refusing to continue Medicaid funding prior to the holding of an evidentiary hearing on whether the home was in compliance with applicable state and federal requirements. The district court granted a preliminary injunction and ordered the agencies not to terminate funding pending the requested hearing (Pet. App. 24-41).

The court of appeals reversed, holding that there is no statutory or constitutional entitlement to a hearing prior to an initial decision not to renew a Medicaid funding agreement with a nursing home (Pet. App. 16-23).

2. The decision of the court of appeals is correct and further review is unwarranted. To begin with, petitioner had "at most a unilateral hope that new provider agreements would be executed, but such unilateral hope cannot constitute a protected 'property' interest * * *" (Pet. App. 21). Pursuant to applicable statutory and regulatory provisions, the provider agreements expired after one year and contained no renewal provisions. See 42 U.S.C. (& Supp. III) 1395cc(a)(1); 42 C.F.R. 442.15(a). As the

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titled to take an administrative appeal. 42 C.F.R. 405.1501-405.1518. If the initial nonrenewal decision is upheld on reconsideration, the facility may obtain a hearing before an administrative law judge. See 42 C.F.R. 405.1510-405.1560.

court of appeals observed (Pet. App. 21), "[t]he manifest intent of limiting the term of a provider agreement to one year is to assure that an automatic termination occurs and a new agreement may be entered into if the facility is in compliance." Before the renewal of a provider agreement, the State must assure the Secretary that the home is licensed and must certify that the facility is in compliance with federal standards (*id.* at 20-21). In these circumstances, "[t]he Home understood that a new [provider agreement] would not issue unless it could affirmatively show it was qualified" (*id.* at 21). Thus, the court below properly concluded that this case is controlled by *Board of Regents* v. *Roth*, 408 U.S. 564 (1972). Here, as in *Roth*, petitioner has not shown a "legitimate claim of entitlement" to renewal. *Id.* at 577. Accordingly, petitioner "did not have a *property* interest sufficient to require the [Secretary] to give [it] a hearing when [he] declined to renew" the provider agreement. *Id.* at 578 (emphasis in original). See, *e.g.*, *State Department of Social Services* v. *Rodvik*, 264 N.W.2d 898, 902 (S.D. 1978); *Paramount Convalescent Center, Inc.* v. *Department of Health Care Services*, 15 Cal.3d 489, 542 P.2d 1, 125 Cal. Rptr. 265 (1975), cert. denied, 425 U.S. 992 (1976); *Marshall Nursing Homes, Inc.* v. *Aggrey*, 50 Ohio App.2d 15, 361 N.E.2d 522 (1976); see also *Green* v. *Cashman*, 605 F.2d 945, 946 (6th Cir. 1979).[3]

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[3] Most of the cases cited by petitioner (Pet. 8-10) for the proposition that it has a property interest in renewal of its provider agreements are distinguishable because they concern the *termination* of an agreement during its effective period (see 42 C.F.R. 405.604(c)(2) (1979)) rather than the *failure to renew* a provider agreement. In *Rockhill Care Center, Inc.* v. *Harris*, 502 F. Supp. 1227, 1232 (W.D. Mo. 1980), the dis-

In any event, whatever the nature of petitioner's interest in renewal, that interest is adequately protected by the Secretary's present administrative review procedures, which provide for substantial opportunities to be heard prior to the Secretary's initial decision to terminate or not renew a provider agreement, and for administrative appeal and an evidentiary hearing following the Secretary's initial decision. See *Town Court Nursing Center, Inc.* v. *Beal*, 586 F.2d 266, 275-278 (3d Cir. 1978) (en banc);[4] *Case* v. *Weinberger*, 523 F.2d 602 (2d Cir. 1975). Petitioner had an opportunity to participate in those review proceedings, and to submit information and arguments in support of its contention that its contract should be renewed.

The existing procedures thus provide all the process that is constitutionally due. See *Mathews* v. *El-*

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trict court expressed "serious misgivings" about the home's assertion of a right to a pre-renewal hearing, but it granted a preliminary injunction against the Secretary because it found that the residents had no adequate alternative place to live. While we believe that *Rockhill* was wrongly decided, the district court in that case recognized the general rule that an evidentiary hearing is not required before the denial of a renewal application or before termination of a contract in accordance with its own provisions. *Id.* at 1234. This general rule applies in the instant case.

[4] Petitioner is incorrect in contending (Pet. 11-12) that there are "material distinctions" between *Town Court* and this case based on the nature of the evidence before the Secretary. In both cases the Secretary's initial decision did not turn primarily on credibility issues and the facilities had the opportunity, prior to decision, to make documentary submissions. While petitioner contends that some surveyors are not health care professionals, no such finding was made below, and, in any event, this was also the case in *Town Court*. See 586 F.2d at 271.

dridge, 424 U.S. 319 (1976). A nursing home is not the intended beneficiary of the Medicare/Medicaid programs.[5] Without government funding, it may still operate and provide care for private patients. In addition, more elaborate procedures than those presently available would be contrary to the strong public interests in insuring compliance with regulations governing adequate care for the elderly and infirm, and in the efficient allocation of limited financial and administrative resources. See *Mathews* v. *Eldridge*, *supra*, 424 U.S. at 347-349; *Town Court Nursing Center, Inc.* v. *Beal*, *supra*, 586 F.2d at 278.[6]

3. Alternatively, petitioner argues (Pet. 13-14) that two federal statutes mandate a pre-renewal hearing. These arguments are insubstantial. As the legislative history makes clear, the first statute on

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[5] The district court granted petitioner's request for a preliminary injunction primarily on the basis of the "transfer trauma" that its residents might suffer as the result of changing homes (Pet. App. 29). But in *O'Bannon* v. *Town Court Nursing Center*, 447 U.S. 773 (1980), this Court found that despite the severe physical or emotional side effects that a transfer may have on the patients, those patients do not have a property right entitling them to contest decertification of a facility. Clearly, a nursing home is in no better position to assert a property interest based on "transfer trauma" than are the patients themselves.

[6] Petitioner cites (Pet. 9) the decision in *Hathaway* v. *Mathews*, 546 F.2d 227 (7th Cir. 1976), which held that a nursing home was entitled to a hearing before revocation of its Medicaid authorization. But that decision was expressly grounded on "factors peculiar to this litigation." *Id.* at 232. In marked contrast to this case, the home in *Hathaway* had no notice or opportunity to respond prior to the termination and there appeared to be a dispute between the state and federal governments over whether violations warranting sanction had occurred.

which petitioner relies, 42 U.S.C. 1395ff(c), merely provides for a hearing before a "final" decision of the Secretary. See S. Rep. No. 404, 89th Cong., 1st Sess. 51 (1965). The issue in this case, on the other hand, is whether petitioner is entitled to a hearing before the Secretary's "initial" decision. See 42 C.F.R. 405.1502.

Petitioner's reliance on Pub. L. No. 96-499, Section 916, 94 Stat. 2623 (to be codified as 42 U.S.C. 1395cc(f)), is similarly misplaced. That statute creates a suspension sanction as an "alternative to decertification" and "in lieu of terminating the agreement or certification of the facility" (Section 916(a)(f)(1)(B)) during the term of the contract. It allows the Secretary to suspend payments to the provider (Section 916(a)(f)(1)(B)), after a hearing (Section 916(a)(f)(2)), until "the Secretary finds that the facility is in substantial compliance (or is making good faith efforts to achieve substantial compliance)" (Section 916(a)(f)(3)). The statute has no application to this case, however, because petitioner's violations and the Secretary's actions here occurred more than one year before the statute's effective date. Section 916 is also inapplicable because it creates a sanction to be imposed during the term of an agreement and does not concern a decision not to renew. Furthermore, even if a decision not to renew is viewed as a termination and decertification (contrary to 42 C.F.R. 405.604(c)(2)(1979)), in enacting Section 916 Congress expressly intended to leave decertification procedures unaffected. H.R. Conf. Rep. No. 96-1479, 96th Cong., 2d Sess. 141 (1980).[7]

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[7] Petitioner also argues (Pet. 13) that Colorado statutes regarding licensing and patient rights gave petitioner a right

It is therefore respectfully submitted that the petition for a writ of certiorari should be denied.

LAWRENCE G. WALLACE
Acting Solicitor General

AUGUST 1981

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to a pre-renewal hearing with respect to the provider agreement. Neither court below addressed this contention and it is without merit. First, petitioner's state license to operate a nursing home did not create a concomitant right to federal government funding. Moreover, the federal government's decision not to renew petitioner's government-funding contract did not limit or condition the rights conferred upon petitioner by the state operating license. Second, whatever the residents' rights may be under Colorado law, the residents have chosen not to petition this Court for review, and, pursuant to prudential standing limitations, petitioner should not be permitted to base its claim on the rights of those third parties. See *Singleton* v. *Wulff*, 428 U.S. 106, 113-116 (1976) (plurality opinion); *id.* at 123-125 (opinion of Powell, J.); *Warth* v. *Seldin*, 422 U.S. 490, 499, 509-510 (1975).

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No. 80-2085

In the Supreme Court of the United States

OCTOBER TERM, 1980

GERIATRICS, INC., d/b/a EVENTIDE OF LAKEWOOD NURSING HOME, PETITIONER

v.

RICHARD S. SCHWEIKER, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE TENTH CIRCUIT

SUPPLEMENTAL MEMORANDUM FOR THE FEDERAL RESPONDENTS IN OPPOSITION

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In its petition for certiorari, petitioner contended (Pet. 9) that the court of appeals' decision in this case conflicts with the decision of the Seventh Circuit in *Hathaway* v. *Mathews*, 546 F.2d 227 (1976). In our memorandum in opposition (at 6 n.6), we noted that *Hathaway* should be limited to its particular facts, which are distinguishable from those of the present case. A recent decision of the Seventh Circuit demonstrates that that court is in complete agreement with the conclusion of the court below that a nursing home is not entitled to a hearing prior to the Secretary's initial decision to terminate or not

renew a Medicare or Medicaid provider agreement. In *Northlake Community Hospital* v. *United States*, No. 80-2268 (7th Cir. July 21, 1981),[1] the Seventh Circuit, relying on the factors set forth in *Mathews* v. *Eldridge*, 424 U.S. 319, 335 (1976), held that Medicare providers do not have a colorable constitutional claim of entitlement to a pre-termination hearing (App., *infra*, 15a-18a). Citing with approval the decision of the court of appeals in the instant case, the Seventh Circuit concluded that "the post-termination hearing provided under Medicare regulations adequately meets a provider's due process objections" (*id.* at 18a).[2] The decision in *Northlake* lends additional support to our argument that the decision below is correct and does not warrant further review.

For the foregoing reasons and the reasons stated in our memorandum in opposition, it is respectfully submitted that the petition for a writ of certiorari should be denied.

REX E. LEE
Solicitor General

SEPTEMBER 1981

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[1] We are reproducing the *Northlake* opinion in an appendix to this supplemental memorandum.

[2] The Seventh Circuit in *Northlake* distinguished its earlier decision in *Hathaway* for reasons that are equally applicable here. App., *infra*, 18a-19a n.10.

APPENDIX

IN THE UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

No. 80-2268

NORTHLAKE COMMUNITY HOSPITAL,
PLAINTIFF-APPELLANT

v.

THE UNITED STATES OF AMERICA,
THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
and RICHARD S. SCHWEIKER,* Secretary of the
Department of Health and Human Services,
DEFENDANTS-APPELLEES

Appeal from the United States District Court for
the Northern District of Illinois, Eastern Division

No. 80 C 4157—GEORGE N. LEIGHTON, *Judge*

ARGUED DECEMBER 9, 1980—DECIDED JULY 21, 1981

Before BAUER and CUDAHY, *Circuit Judges*, and BARTELS, *Senior District Judge.***

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* We substitute the name Richard S. Schweiker, the successor to the original defendant, Patricia R. Harris, as Secretary of Health and Human Services pursuant to Fed. R. App. P. 43(c).

** The Honorable John R. Bartels, Senior United States District Judge for the Eastern District of New York, is sitting by designation.

CUDAHY, *Circuit Judge.* Plaintiff-appellant, Northlake Community Hospital ("Northlake"), appeals from the district court's dismissal of its suit for injunctive relief against the United States of America, the Department of Health and Human Services ("DHHS") and Richard S. Schweiker, Secretary of Health and Human Services (the "Secretary").[1] Northlake's complaint, filed on August 6, 1980, claimed that the Federal Defendants violated the hospital's right to due process by failing to conduct a hearing prior to the termination of Northlake's Medicare provider agreement. On August 20, 1980, the district court dismissed the complaint with prejudice on the grounds that Northlake failed to establish subject matter jurisdiction and failed to state a claim upon which relief could be granted. Northlake seeks review of both the district court's final judgment dismissing its complaint and a subsequent order denying reconsideration of the dismissal. We affirm.

I.

Title XVIII of the Social Security Act, 42 U.S.C. § 1395 (1979), sets forth the statutory requirements for participation in the federally funded Medicare program. This program, administered by the Department of Health and Human Services (formerly the Department of Health, Education and Welfare) provides health insurance benefits for aged and disabled persons by making payments directly to the institution or individual providing the health service or care (rather than to the individual beneficiary). 42 U.S.C. § 1395c and f (1979). In order to receive payment for services rendered to a Medicare patient,

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[1] The United States of America, the DHHS and the Secretary will hereinafter be referred to as the Federal Defendants.

an institution must meet the conditions of participation prescribed by the Social Security Act and accompanying regulations. *See* 42 U.S.C. § 1395 (1979) and 42 CFR § 405.1011 *et seq.* (1980). The institution then becomes eligible to execute a one year renewable provider agreement with the government. 42 U.S.C. § 1395cc (1979). Institutions certified as Medicare providers are subject to periodic surveys by state agencies designated by the Secretary to evaluate compliance with federal standards. 42 U.S.C. § 1395aa (1979) and 42 CFR § 405.1904 (1980). If the institution fails to maintain compliance with the prescribed conditions of participation, the Secretary has the authority to terminate the institution's provider agreement at any time. 42 U.S.C. § 1395cc(b)(2) (1979) and 42 CFR § 489.53(a)(3) (1980).

Northlake, the plaintiff-appellant here, is a full-service 115 bed hospital, which has been certified as a Medicare provider since the program's inception in 1967. The hospital, which employs a staff of 350 doctors, nurses and support personnel, receives more than $2,000,000 a year from the federal government in payment for Medicare services. This payment represents approximately 20% of the hospital's total yearly revenue.

In late November 1979, the hospital administrator received written notice that the Federal Defendants were initiating action to terminate Northlake's Medicare provider agreement because the hospital no longer qualified for participation in the program. Included in the letter of notification was a list of deficiencies found by inspectors from the Illinois Department of Public Health during post-certification visits to Northlake in July, August and September 1979. According to the state survey, Northlake failed

to comply with four conditions of participation: Physical Environment, 42 CFR § 405.1022 (1980); Medical Staff, 42 CFR 405.1023 (1980); Dietary Department, 42 CFR § 405.1025 (1980); and Laboratories, 42 CFR 405.1028 (1980). The most serious deficiencies cited by the inspectors involved violations of the National Fire Protection Association's Life Safety Code, which is incorporated in the Medicare Physical Environment condition. *See* 42 CFR § 405.1022B (1980). The letter urged Northlake to contact the Federal Defendants if the hospital had taken steps to correct the deficiencies or had definite plans for doing so, but warned that, absent compliance, notice of a termination date was imminent.

Six months passed before Northlake responded to the Federal Defendants' notice of deficiencies. On June 1, 1980, the hospital administrator informed the DHHS Regional Health Standard Quality Office that "substantial progress [had] been made toward compliance." Although the administrator explained that Northlake had corrected or eliminated most of the deficiencies, two major Life Safety Code violations remained. First, the hospital failed to provide "at least two exits [on each floor or fire section] which are remote from each other and one of which is a door leading directly outside the building or to an interior stairway leading outside the building." Defendants' Br., App. C. Second, "every aisle, passageway, corridor exit discharge, exit location and access [did] not have a readily available egress leading to an exit." *Id.* In response to the first deficiency, the administrator could only report that plans for an additional stairway from the fourth floor to the first floor had been submitted to the state "some time back" and would be "completed as soon as funds [were] avail-

able." Correction of the second deficiency, however, required such extensive and costly repair that the administrator requested a waiver of this condition because "the safety benefit to be derived [did] not justify the cost."

After reviewing the hospital administrator's response and the results of an additional survey conducted in January 1980, the Federal Defendants notified Northlake on July 18, 1980, that its Medicare provider agreement would be terminated effective August 8, 1980, due to "the existence of serious deficiencies which limit the capacity of your facility to render care without hazard to the health and safety of your patients." The letter of termination explained that the Life Safety Code violations found in both the July-September 1979 and January 1980 surveys formed the basis for the Federal Defendants' decision. Since several of the deficiencies found during the January 1980 survey had not previously been reported to the hospital, a list of these deficiencies was attached to the letter. The Federal Defendants also informed Northlake that it could challenge the decision by submitting a written request for a hearing within 60 days of the notice of termination.

The hospital administrator immediately demanded that the Federal Defendants rescind the termination order. While readily admitting that certain Life Safety Code violations had not been corrected, the administrator argued that "none of the deficiencies cited have a bearing on the quality of care provided to patients in our hospital, nor is the safety of our patients in jeopardy." He suggested that the Federal Defendants meet with Northlake administrators to formulate a mutually agreeable plan for correcting the deficiencies. In the event that the Federal De-

fendants chose not to rescind the order, the administrator also made a separate request for a prompt hearing on the matter.

When no hearing was scheduled prior to the August 8 termination date, the hospital filed suit for injunctive relief. In a verified complaint dated August 6, 1980, Northlake charged that the Federal Defendants had violated the hospital's constitutional rights by failing to conduct a hearing prior to the termination of Northlake's Medicare provider agreement. The hospital claimed that the court had jurisdiction pursuant to 28 U.S.C. § 1331(a) (1976).[2] Shortly thereafter, the Federal Defendants filed a motion to dismiss the action on the grounds that federal jurisdiction was precluded by 42 U.S.C. § 405 (h) (1976).[3] *See Weinberger* v. *Salfi*, 422 U.S. 749 (1975). In addition, the Federal Defendants argued that Northlake was not entitled to a hearing prior to the termination of its provider agreement and that

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[2] 28 U.S.C. § 1331(a) (1976) (amended 1976 and 1980) provides:

> The district courts shall have original jurisdiction of all civil actions wherein the matter in controversy exceeds the sums or value of $10,000 exclusive of interest and costs, and arises under the Constitution, laws or treaties of the United States.

[3] 42 U.S.C. § 405(h) (1976) provides:

> The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 41 of Title 28 [28 U.S.C. § 1331(a) (1976)] to recover on any claim arising under this subchapter.

Northlake had failed to exhaust the administrative remedies available to it.

The district court heard argument on the jurisdictional issue at a hearing on August 15, 1980. During these arguments, Northlake maintained that the court had jurisdiction over its constitutional claims pursuant to 42 U.S.C. § 405(g) (1976)[4] even though the complaint stated that the court's jurisdiction was based on 28 U.S.C. § 1331(a) (1976). Moreover, Northlake admitted that the hospital was not entitled to a full evidentiary hearing prior to the termination of its provider agreement, but insisted that the Federal Defendants were required to provide preliminary pre-termination procedures which conformed with due process. *See O'Bannon* v. *Town Court Nursing Center, Inc.*, —— U.S. ——, 48 U.S.L.W. 4842 n.6 (1980); *Town Court Nursing Center, Inc.* v. *Beal*, 586 F.2d 266 (3d Cir. 1978). At the close of the hearing, the district court dismissed Northlake's complaint with prejudice on the grounds that the hospital failed to establish subject matter jurisdiction and failed to state a claim upon which relief could be granted.

Northlake submitted an amended complaint to the district court on September 4, 1980, and renewed its motion for injunctive relief. In the amended com-

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[4] 42 U.S.C. § 405(g) (1976) provides:

> Any individual, after any final decision of the Secretary made after a hearing to which he was a party, irrespective of the amount in controversy, may obtain a review of such decision by a civil action commenced within sixty days after the mailing to him of notice of such decision or within such further time as the Secretary may allow. Such action shall be brought in the district court of the United States for the judicial district in which the plaintiff resides, or has his principal place of business, ...

plaint, Northlake revised its jurisdictional statement to conform to the position that it had taken during oral argument on defendants' motion to dismiss. The hospital also revised and clarified its due process claim. The amended complaint thus alleged that the Federal Defendants violated the hospital's constitutional rights by: 1) failing to provide Northlake with prior notification of the new set of deficiencies (i.e., deficiencies found during the January 1980 survey); 2) failing to allow Northlake to submit a plan for achieving compliance with those deficiencies; 3) failing to provide an "exit interview;" and 4) failing to permit Northlake to submit additional evidence after notification of the new deficiencies.

When the court refused to accept the amended complaint because the previous action had been dismissed with prejudice, Northlake made an oral motion pursuant to Rule 59(e) of the Federal Rules of Civil Procedure to have the court reconsider its August 20 judgment dismissing the complaint. Since Rule 59 (e) requires that a motion to alter or amend a judgment be filed within 10 days of the judgment, the Federal Defendants argued that Northlake's motion was untimely. Northlake responded that the relief it requested could also be granted under Rule 60(b). The district court concluded, however, that Northlake's Rule 59(e) motion was not timely and that Rule 60(b) was not available to cure the jurisdictional defect.

Northlake filed this appeal on September 8, 1980. Pursuant to an order of this court dated October 7, 1980, defendants have restored Northlake's provider status retroactive to August 8, 1980, and have honored the hospital's Medicare claims pending a decision by the court on this matter.

II.

In *Weinberger* v. *Salfi*, 422 U.S. 749 (1975), the Supreme Court held that a plaintiff challenging the denial of Social Security benefits on constitutional grounds could not establish jurisdiction in the district court under 28 U.S.C. § 1331(a) (1970). The basis for this restriction on federal question jurisdiction was the third sentence of 42 U.S.C. § 405(h) (1970) which provides that "no action against the United States, the Secretary or any officer or employee thereof shall be brought under [§ 1331 *et seq.*] of Title 28 to recover on any claim arising under [Title II of the Social Security Act.]." [5] Although the language of § 405(h) only addresses claims arising under Title II of the Social Security Act, the Court concluded that constitutional claims resulting from the denial of Title II benefits were covered by the 405(h) restriction. Thus, the Court explained,

> [N]ot only is it Social Security benefits which appellees seek to recover, but it is the Social Security Act which provides both the standing and the subjective basis for the presentation of their constitutional contentions. . . . To contend that such an action does not arise under the Act whose benefits are sought is to ignore both the language and substance of the complaint and the judgment.

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[5] As the Supreme Court noted in *Salfi*, the language of Section 405(h) actually bars actions under 28 U.S.C. § 41(1970). At the time Section 405(h) was enacted, however, Section 41 contained all of the grants of jurisdiction to the United States district courts under Title 28 including the predecessor to Section 1331(a). *Salfi*, 422 U.S. at 756, n.3.

Id. at 760-61. The *Salfi* Court emphasized that § 405(h) does not preclude all constitutional challenges to the provisions of the Social Security Act, but "simply require[s] that [such claims] be brought under the jurisdictional grants contained in the Act." *Id.* at 762.

Subsequent efforts to apply the reasoning of *Salfi* to disputes arising under Title XVIII of the Social Security Act have resulted in a conflict among the judicial circuits.[6] In *Trinity Memorial Hospital of Cudahy, Inc.* v. *Associated Hospital Services*, 570 F.2d 660 (7th Cir. 1977), this court agreed that *Salfi* "precludes the useof 28 U.S.C. § 1331 as a jurisdictional basis" for Medicare provider reimbursement

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[6] At least three circuits ruled that the Supreme Court's reasoning in *Salfi* did not necessarily preclude § 1331 jurisdiction in these cases. *See e.g., Humana of South Carolina, Inc.* v. *Califano*, 590 F.2d 1070 (D.C. Cir. 1978) (§ 405(h) is not summoned into play when suit is brought to vindicate an interest in procedural regularity); *Dr. John T. McDonald Foundation, Inc.* v. *Mathews*, 554 F.2d 714 (5th Cir. 1977), *vacated*, 571 F.2d 328, *cert. denied*, 439 U.S. 893 (1978) (§ 1331 jurisdiction exists for claims arising prior to the availability of adequate statutory review under the Act); *St. Louis University* v. *Blue Cross Hospital Service, Inc.*, 537 F.2d 283 (8th Cir.), *cert. denied sub nom. Faith Hospital Ass'n.* v. *Blue Cross Hospital Service, Inc.*, 429 U.S. 977 (1976) (§ 405(h) does not preclude district court jurisdiction of due process challenges to the procedures adopted by the Secretary to determine Medicare reimbursements). The Second Circuit concluded that *Salfi* effectively cut off federal question jurisdiction under Section 1331(a) in these cases, but found that the Court of Claims had exclusive jurisdiction to review reimbursement disputes. *South Windsor Convalescent Home, Inc.* v. *Mathews*, 541 F.2d 910 (2d Cir. 1976). *Accord, Whitecliff, Inc.* v. *United States*, 536 F.2d 347 (Ct. Cl. 1976), *cert. denied*, 430 U.S. 969 (1977).

disputes. Although Northlake's claim in the instant case involves the procedures for terminating a provider agreement rather than the procedures for obtaining reimbursement pursuant to such an agreement, the result with respect to these two procedures should be the same. Under *Salfi* and *Trinity*, Northlake's allegation of federal question jurisdiction is defective.

The Federal Rules of Civil Procedure, however, allow for the liberal amendment of pleadings, particularly to cure jurisdictional defects. *See* 3 Moore's Federal Practice § 15.10 at 15-140 (2d ed. 1980). Rule 15(a) provides that "a party may amend his pleading once as a matter of course at any time before a responsive pleading is served." It is well settled in this circuit that a motion to dismiss is not a responsive pleading. *Fuhrer* v. *Fuhrer*, 292 F.2d 140 (7th Cir. 1961). Therefore, Northlake was entitled to amend its complaint "as a matter of course" at any time prior to the dismissal of the action. Northlake's effort to assert alternative jurisdictional grounds, as demonstrated by its written memorandum in opposition to defendant's motion to dismiss and oral argument on that motion, was sufficient in our view, to effectively amend the complaint and to foreclose dismissal of the suit on the basis of Northlake's defective allegation of federal question jurisdiction.[7]

It remains necessary, however, to determine whether the amended complaint, which alleges jurisdiction pursuant to 42 U.S.C. § 405(g) (1979), confers subject mater jurisdiction on the district court. Title XVIII of the Social Security Act specifically

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[7] Since the issue is not relevant to our disposition of this case, we express no opinion on the propriety of Northlake's effort to amend the complaint after dismissal of the action.

states that an institution dissatisfied with a final decision by the Secretary to terminate its Medicare provider agreement may obtain judicial review of the matter in accordance with 42 U.S.C. § 405(g). 42 U.S.C. § 1395ff(c) (1979).[8] Under the terms of Section 405(g),[9] review is available only if three requirements have been satisfied: 1) an action was brought "after any final decision of the Secretary made after a hearing to which [the provider] was a party;" 2) the action was commenced within 60 days after the mailing of the notice of decision by the Secretary or within such time as the Secretary may allow; and 3) the action was filed in an appropriate court. 42 U.S.C. § 405(g) (1979).

The Supreme Court has found that the first requirement, a final decision by the Secretary after a hearing, is "central to the requisite grant of subject matter jurisdiction" under Section 405(g). *Salfi*, 422 U.S. at 764. In the instant case, Northlake sued for injunctive relief before any final decision after a hearing could be obtained. Although Northlake's apparent failure to exhaust available administrative remedies would seem, on its face, to defeat Section 405(g) jurisdiction, Northlake argues that this case

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[8] 42 U.S.C. § 1395ff(c) (1979) provides:

> Any institution or agency dissatisfied with any determination by the Secretary that it is not a provider of services, or with any determination described in section 1395cc (b)(2) of this title, shall be entitled to a hearing thereon by the Secretary (after reasonable notice and opportunity for hearing) to the same extent as is provided in section 405(b) of this title, and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.

[9] *See* note 4 *supra*.

falls within an exception to the final decision requirement.

In *Mathews* v. *Eldridge*, 424 U.S. 319 (1976), the Supreme Court explained that there are two prerequisites to a final decision by the Secretary. The first such prerequisite is a purely jurisdictional requirement which cannot be waived, namely the presentation of a claim for benefits to the Secretary. The Court noted that "absent such a claim there can be no 'decision' of any type. And some decision by the Secretary is clearly required by the statute." *Id.* at 329.

Northlake satisfied this first prerequisite by presenting an appropriate claim to the Secretary upon receipt of the termination notice. In a letter dated July 28, 1980, the hospital administrator demanded immediate rescission of the termination order on the ground that the cited deficiences did not affect the quality of care provided by the hospital or the safety of its patients. Although the administrator did not deny the existence of Life Safety Code violations, his general challenge to the termination decision was adequate in this case to meet the "presentation of claim" requirement even though there was no genuine dispute as to the existence of the deficiencies. Here, instead, there is a dispute as to the length of time the institution should be given to achieve compliance.

The second prerequisite to a "final decision" by the Secretary requires the exhaustion of administrative remedies; but, there are circumstances under which this element can be waived. If the Secretary determines that additional administrative review would be futile—either because the agency's needs have been satisfied or because the requested relief is beyond the agency's power to confer—the Secretary

may waive the exhaustion requirement at any stage of the administrative process. *Salfi*, 422 U.S. at 765-67. Similarly, if the claimant raises a constitutional challenge which is entirely collateral to his claim of entitlement, and "the claimant's interest in having . . . [the] issue resolved promptly is so great that deference to the agency's judgment is inappropriate," the court may waive the exhaustion requirement. *Eldridge*, 424 U.S. at 318. In the case of waiver either by the Secretary or the court, a claimant who has satisfied all of the other prerequisites for jurisdiction under Section 405(g) may obtain judicial review without exhausting available administrative remedies.

In the instant case, Northlake argues that the due process violations alleged in its complaint represent colorable constitutional claims sufficient to mandate a waiver of the exhaustion prerequisite to Section 405(g) jurisdiction. Northlake specifically charged that the Federal Defendants violated the hospital's right to due process by failing (1) to conduct a hearing prior to the termination of Northlake's Medicare provider agreement, (2) to provide Northlake with prior notification of the "new" deficiencies (of January 1980), (3) to allow Northlake to submit a plan for achieving compliance with those deficiencies, (4) to provide an "exit interview" and (5) to permit Northlake to submit additional evidence after notification of the new deficiencies.

We have examined each of these allegations, however, and are persuaded that Northlake failed to satisfy its burden. The mere *assertion* of a constitutional claim is not enough; the record before the court must present a colorable constitutional claim. *Kechijian* v. *Califano*, 621 F.2d 1, 5 (1st Cir. 1980).

The facts contained in this record demonstrate that Northlake's charges do not rise to the level of colorable constitutional claims and could not confer subject matter jurisdiction on the district court pursuant to 42 U.S.C. § 405(g) (1979).

Northlake's first claim, that due process requires a hearing prior to the termination of Medicare benefits, has been in a similar context rejected by the Supreme Court. In *Mathews* v. *Eldridge*, 424 U.S. 319 (1976), the Court examined the procedures governing administrative review of disability claims under the Social Security Act. These procedures, which are almost identical to the administrative prescriptions for Medicare providers, allow only for hearings after the denial of the disability claims. The Court nevertheless determined that these provisions satisfy the requirements of due process. In arriving at this conclusion, the Court examined the statutory scheme in light of the particular individual and governmental interests at stake:

> First, the private interest that will be afffected by the official action; second, the risk of an erroneous deprivation of such an interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail.

Eldridge, 424 U.S. at 335. Under these criteria, we believe that Medicare providers, like disability claimants in *Eldridge*, cannot raise a colorable constitutional claim of entitlement to a pre-termination hearing.

The private interest involved in the termination of a Medicare provider agreement is less weighty than the interest of a disability claimant. *Town Court Nursing Center, Inc.* v. *Beal*, 586 F.2d 266 (3d Cir. 1978). The provider, although it plays a virtually indispensible role in the administration of Medicare benefits, is *not* the intended beneficiary of the Medicare program. *Id.* at 277. Obviously, the termination of Medicare assistance has a financial impact (potentially severe in many instances) on the institution. But a provider's financial need to be subsidized for the care of its Medicare patients is only "incidental to the purpose and design of the [Medicare] program." *Geriatrics, Inc.* v. *Harris*, 640 F.2d 262 (10th Cir. 1981). Thus, a terminated provider can still obtain revenue from the care of private patients. "The unfortunate reality that [the institution] will probably encounter difficulty operating at capacity is not of constitutional significance." *Id.* at 8. *Accord, Town Court*, 586 F.2d at 277; *Case* v. *Weinberger*, 523 F.2d 602, 607 (2d Cir. 1975).

The risk of erroneous deprivation of provider status is also quite manageable. As the Court of Appeals for the Third Circuit explained in *Town Court*:

> The decision not to renew a provider agreement is an easily documented, sharply focused decision in which the issues of credibility and veracity play little role. It is based in most cases upon routine, standard, unbiased reports by health care professionals. Those professionals evaluate the provider in light of well-defined criteria that were developed in the administrative rule making process. Written submissions are adequate to allow the provider to present his case. Given the extensive documentation that the provider is

> able to submit in response to the findings of the survey teams, the provider is unlikely to need an evidentiary hearing to present his position more effectively.

Town Court, 586 F.2d at 277.

Finally, the Government's interest in expeditious provider termination procedures is twofold. The Secretary's responsibility for insuring the safety and care of elderly and disabled Medicare patients is of primary importance. In addition, the government has a strong interest in minimizing the expenses of administering the Medicare program. Courts which have reviewed this problem agree that the cost of providing pre-termination hearings to all disgruntled providers would be excessively high. *Town Court*, 586 F.2d 278. Hence, when the Government's strong interest in simplicity and expedition and the relatively small risk of error are balanced against the provider's interest, a provider's due process rights appear to be adequately protected by a post-termination hearing. *Town Court Nursing Center* v. *Beal*, 586 F.2d 266 (3d Cir. 1978).

Although the Supreme Court has never directly addressed the pre-termination hearing question in the context of terminating a Medicare provider, the Court recently delivered itself of persuasive, if not dispositive, dicta on the subject. Thus in *O'Bannon* v. *Town Court Nursing Center*, —— U.S. ——, 48 U.S.L.W. 4842 (1980), the Court held that Medicaid patients were not entitled to a hearing prior to their transfer from an institution whose provider agreement had been terminated. The Court stated that, "the patients argue that they are third party beneficiaries of the provider agreement . . . and that this

status somehow entitles them to more than [the provider] itself is entitled to—namely, a pretermination hearing." *Id.* at 4845 n.17. This observation by the Court in *O'Bannon*, as well as the *Eldridge* due process analysis, makes it clear that the post-termination hearing provided under Medicare regulations adequately meets a provider's due process objections. *Accord, Geriatrics, Inc.* v. *Harris*, 640 F.2d 262 (10th Cir. 1981); *Royal Manor, Inc.* v. *Califano*, 620 F.2d 304 (6th Cir. 1980); *Green* v. *Cashman*, 605 F.2d 945 (6th Cir. 1979); *Canton Ridge Nursing Home, Inc.* v. *Califano*, 596 F.2d 608 (4th Cir. 1979); *Case* v. *Weinberger*, 523 F.2d 602 (2d Cir. 1975); *Rockhill Care Center, Inc.* v. *Harris*, 502 F. Supp. 1227 (W.D. Mo. 1980). Accordingly, Northlake's claim to a pre-termination hearing does not rise even to the level of a colorable constitutional claim, and the principal asserted jurisdictional basis of the complaint must therefore fail.[10]

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[10] In supporting its claim for a pre-termination hearing, Northlake relied heavily on this court's decision in *Hathaway* v. *Mathews*, 546 F.2d 227 (7th Cir. 1976). In that case, we held that the Secretary could not terminate Medicaid payments to a nursing home until the home had been given notice of the charges and a hearing in which the validity of the charges could be challenged. The result was carefully tailored to a "balancing of factors peculiar to [that] litigation," *Id.* at 232, and must be limited to those facts in light of the Supreme Court's decisions in *Eldridge* and *O'Bannon*.

Since *Hathaway* is factually distinguishable from the instant case in several respects, Northlake's reliance on the case is misplaced. Unlike Northlake, the nursing home in *Hathaway* had no opportunity to obtain administrative review of the Secretary's decision because the applicable regulations did not then provide for a post-termination hearing. Moreover, the nursing home in *Hathaway* received no advance notice of the alleged deficiencies requiring termination of the

Northlake also argues that the Federal Defendants failed to provide the hospital with prior notice of the deficiencies which caused the termination and refused to allow Northlake to respond to those deficiencies. Specifically, Northlake maintains that it should have been allowed to submit a plan for achieving compliance with respect to the deficiencies cited in the termination order, should have been granted an "exit interview" and should have been permitted to submit additional evidence on the deficiencies. We do not believe, however, that based on the record these allegations have enough substance to constitute colorable constitutional claims sufficient to confer Section 405(g) jurisdiction.

Title XVIII of the Social Security Act authorizes the Secretary to terminate an agreement with a provider which does not substantially comply with the appropriate conditions of participation. 42 U.S.C. § 1395cc(b)(2) (1979). The deficient provider may temporarily continue to receive Medicare funds, however, if the existing deficiencies do not jeopardize the health and safety of the patients or seriously limit the provider's capacity to render adequate care. The facility must also submit an acceptable plan for achieving compliance within a reasonable period of time. 42 CFR § 405.1907(a) (1980). Although the

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provider agreements, and there was substantial doubt whether the home was, in fact, out of compliance with Medicaid conditions of participation. While these substantial factual differences render the *Hathaway* result inapplicable to Northlake's situation, the existence of *Hathaway* might suggest that Northlake's claim for a pretermination hearing was sufficiently plausible to be "colorable." But whatever its level of "plausibility," we think the claim is legally defective in that it fails to state a claim upon which relief can be granted.

provider is ordinarily expected to take steps toward achieving compliance within 60 days of the notice of the deficiency, the time allowed depends upon the nature of the violation and the facility's ability to provide safe and adequate care. 42 CFR § 405.1907 (b) (1980). If the Secretary does not approve the provider's plan for achieving compliance or finds that the deficiencies affect the service rendered by the provider and the safety of its patients, the Secretary must give the provider fifteen days notice before terminating the agreement. 42 CFR § 489.53(b)(1) (1980).

In the instant case, Northlake was first notified that it was not in compliance with the Medicare Physical Environment condition of participation in November 1979. At that time, the Federal Defendants issued a warning that unless an acceptable plan of compliance was submitted or the deficiencies corrected, Northlake's provider agreement would be terminated. A DHHS official made subsequent visits to Northlake in January and May 1980 to determine if the hospital was making progress toward compliance. But it was not until June 1, 1980, more than six months after receipt of the termination warning, that Northlake reported to Federal Defendants on the status of the deficiencies. Although many of the minor problems had been corrected or eliminated, two serious Life Safety Code violations remained. Northlake indicated that exit violations would be corrected as soon as funds were available and asked the Federal Defendants to waive the egress violation.

Shortly thereafter, the Federal Defendants notified Northlake that, because the hospital failed to meet the requirements for participation in the Medi-

care program, its provider agreement would be terminated on August 8, 1980. The letter, which included a specific list of deficiencies, also contained a description of the administrative appeal process and encouraged Northlake to reapply to the Medicare program when it was once again in compliance with the conditions of participation. Northlake's administrator immediately made both a written and verbal request to the Federal Defendants to rescind the termination order. He also made a separate request for a prompt administrative hearing, but when it became obvious that the hearing would not take place prior to the effective date of termination, Northlake filed this lawsuit.

These facts establish that Northlake had more than adequate notice of the deficiencies which caused the termination of its provider agreement. The November 25 warning letter issued by the Federal Defendants included a specific list of deficient items, and the July 18 termination letter was accompanied by a similar list. At least two of the Life Safety Code violations discussed in the termination letter were also cited in the November warning letter.

Northlake argues that in addition to these two Life Safety Code violations, the termination letter relied on several new deficiencies found during the January 1980 survey and that the hospital did not receive adequate notice of these new items. Some evidence in the record, however, belies this claim. The hospital administrator's letter of June 1, 1980 was "in reply to [the Federal Defendants'] letter of 25 November 1979 [and] subsequent visits by Mr. Paul Schneider [a DHHS official] on 4 January 1980 and 27 May 1980." This letter seems to indicate that Northlake was aware, if only on an informal basis, of the new de-

ficiencies found during the DHHS follow-up inspections. But even if Northlake did not know of the subsequently reported violations, Northlake's argument that it lacked prior notification does not rise to the level of a colorable constitutional claim. Advance notice and subsequent correction of the January deficiencies would not have altered the fact that Northlake still failed to comply with the exit and egress standards of the Life Safety Code. These two eight month old violations alone were sufficient to justify the termination of Northlake's provider agreement. 42 U.S.C. § 1395cc(b)(2) (1979) and 41 CFR § 489.53(a)(3) (1980).

Similarly, the record does not support the allegation that Northlake was denied an opportunity to respond to the deficiencies causing the termination of its provider agreement. Despite the indication in the regulations that a provider is expected to take some step toward achieving compliance within 60 days of the notice of deficiency, Northlake waited more than six months to submit a plan of compliance. The notice of termination issued shortly thereafter indicated that the Secretary found this plan unacceptable. Northlake nevertheless maintains that it should have been given the opportunity to submit a plan for achieving compliance as to the more recently reported deficiencies. Even if Northlake had been able to submit an acceptable plan within a reasonable period (and this was doubtful in view of the lengthy delay in submitting its first plan and the financial problems plaguing the hospital), two serious Life Safety Code violations would remain uncorrected. Thus, an acceptable plan of compliance directed toward the new deficiencies could not have prevented the termination. A claim based on an alleged absence of an opportu-

nity to submit such a plan does not rise to the level of a colorable constitutional claim.

Northlake also contends that it was denied the opportunity to respond to the deficiencies causing the termination because the Federal Defendants failed to conduct an "exit interview." This claim is not based on a provision in the Social Security Act or the Medicare regulations, but finds its origins in the words of the Third Circuit Court of Appeals in *Town Court Nursing Center* v. *Beal*, 586 F.2d 266 (3d Cir. 1978). The court, discussing why a pre-termination hearing is not necessary for Medicare providers, concluded that written submissions are adequate to protect an institution's due process rights, and "in any event, there is ample opportunity to expand orally upon written submissions during the exit interview or in discussions during the survey itself." *Id.* at 277-78. But this language merely suggests that the exit interview is additional protection for the deficient provider rather than a constitutional statement. Since there is no indication in the complaint that written submissions were inadequate to present Northlake's position, the Federal Defendants' failure in this case to conduct an exit interview does not provide a basis for a colorable constitutional claim sufficient to confer jurisdiction on the district court pursuant to Section 405(g).

Northlake's final claim that it was denied an opportunity to submit additional evidence on the new deficiencies noted in the termination letter similarly lacks constitutional substance. First, there is no allegation in the complaint that Northlake ever offered such evidence to the Federal Defendants and no indication what that evidence might be. Second, it is highly unlikely that any such evidence would have

had an appreciable impact on the Secretary's conclusion that the longstanding exit and egress Life Safety Code violations warranted determination of Northlake's provider agreement. Finally, the procedures governing post-termination administrative review freely allow for the presentation of such evidence and adequately protect a provider's due process rights.

We conclude that the allegations of Northlake's complaint do not constitute colorable constitutional claims sufficient to confer subject matter jurisdiction over this action pursuant to 42 U.S.C. § 405(g) (1979). But even if any of Northlake's allegations constitute "colorable" constitutional claims for jurisdictional purposes, the patent invalidity of these claims renders them at least equally dismissable for failure to state claims upon which relief can be granted. As a matter of law, therefore, on grounds of either or both jurisdictional failure and insufficiency of the pleadings, the judgment of the district court dismissing the complaint (together with the order denying reconsideration of that judgment) is affirmed.

A true Copy:

Teste:

Clerk of the United States Court of Appeals for the Seventh Circuit

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